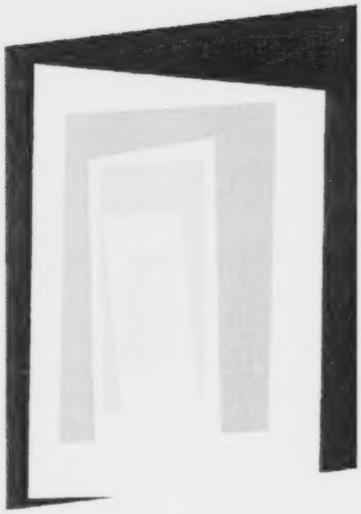

Assessment, Treatment and Community Reintegration of the Mentally Disordered Offender

— FINAL REPORT —

Forensic Mental Health Services
Expert Advisory Panel
– for the –
Ontario Ministry of Health and Long-Term Care

December, 2002

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EXECUTIVE SUMMARY

In January 2001, the Ontario Minister of Health and Long-Term Care established a Forensic Mental Health Services Expert Advisory Panel to consider province-wide operational issues in the context of existing provincial and Ministry policies, and to advise government on a provincial strategy for the implementation of a comprehensive forensic mental health service system, including:

- the inter-ministerial coordination of forensic services;
- the consolidation and clarification of existing provincial and Ministry forensic policies; and
- processes to improve services for forensic clients.

The Panel has identified multiple factors as barriers to the successful implementation of the existing policies and the effective management of the forensic mental health service system in the Province of Ontario.

As a result of its two year review of the existing policies and operational issues, the Panel has concluded that Ontario's forensic mental health service system must comprise a strong inter-ministerial partnership that will provide a fully integrated, accountable, effective and coordinated system of services and supports to meet the needs of mentally disordered persons who come in contact with the law.

The services should be delivered through a continuum of care ranging from highly specialized inpatient services to informal community supports and must provide equitable, stream-lined access to quality care and allow clients to live in the community, to the greatest extent possible.

In addition, the Panel has concluded that a coordinated, appropriately-resourced and clearly articulated long-range plan for the delivery of forensic mental health services will enhance public safety and increase service / system efficiencies.

The Panel has identified the following five categories of issues and, based on its review of the issues, has made 40 recommendations for the Minister's consideration:

1. Leadership and Accountability
2. Information and Data
3. Concepts and Definitions
4. System Capacity and Integration
5. Inter-ministerial Issues

The Panel has also provided appendices setting out the range of forensic services in Ontario, a description of relevant legal issues and a glossary of relevant legal terms.

FORENSIC PANEL RECOMMENDATIONS

1. LEADERSHIP AND ACCOUNTABILITY

1.1. Local and Regional Forensic Human Services and Justice Coordinating Committees

It is recommended that the four partner Ministries (Ministry of Health and Long-Term Care, Ministry of Community, Family and Children's Services, Ministry of Public Safety and Security, Ministry of the Attorney General), with the Ministry of Health and Long-Term Care being the lead Ministry, equally endorse and fund the establishment of local and regional forensic coordinating committees, a key mechanism as per the inter-ministerial report, ***A Provincial Strategy to Coordinate Human Services and Criminal Justice System in Ontario*** ***(Human Services and Justice Coordination Project, 1997).***

It is further recommended that a formal commitment be made by each of the four Ministries to recreate the Provincial Coordinating Committee to provide support and oversee the work of the Human Services and Justice Coordinating Committees throughout the Province. Local and Regional Human Services and Justice Coordinating Committees must liaise with the Ministry of Health and Long-Term Care as the lead Ministry.

1.2. Organization of Mental Health Services

It is recommended that the Ministry of Health and Long-Term Care simplify and disseminate the 20 key junctures from the inter-ministerial report, ***A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario*** ***(Human Services and Justice Coordination Project, 1997), and organize forensic mental health services in accordance with these 20 key junctures.***

1.3. Provincial Administration of Forensic Mental Health Services

It is recommended that the Minister of Health and Long-Term Care, in partnership with related Ministries, establish a visible and recognizable central administrative structure to manage and co-ordinate the forensic mental health system in the Province as an integrated and critical part of the general mental health treatment system.

1.4. Training of Specialized Clinicians, Recruitment and Retention

It is recommended that the Ministry of Health and Long-Term Care support an initiative, under the leadership of representatives from the Academic Health Sciences Programs in Ontario, for the design and implementation of an effective program to facilitate an increase in the number of specialty trained forensic clinicians in the mental health system in Ontario.

1.5. Panel to Meet with Ministry of Health and Long-Term Care Representatives

It is recommended that the Minister of Health and Long-Term Care invite the Panel to reconvene in the Fall of 2003 and annually thereafter to discuss with Ministry representatives the status, implementation strategies and any outstanding operational and policy issues stemming from the Panel's Final Report and its concomitant recommendations.

Leadership and Accountability

A need for a central provincial administrative structure to monitor and manage forensic issues systematically and to shape the development of forensic mental health services.

2. INFORMATION AND DATA

2.1. Development of a Forensic Policies and Procedures Manual

It is recommended that the Ministry of Health and Long-Term Care, in partnership with the Ministry of the Attorney General, Ministry of Public Safety and Security, and Ministry of Community, Family and Children's Services, develop a Forensic Policies and Procedures Manual to ensure consistency in the delivery of forensic services across Regional Forensic Programs throughout the Province of Ontario.

2.2. A Comprehensive Plan for a Coordinated Provincial Forensic System Must Be Developed and Communicated

It is recommended that all forensic documents that have contributed to provincial forensic policy be coalesced to develop a comprehensive plan for a coordinated provincial forensic system for the Province. The resultant policy document must be sanctioned by the Ministry of Health and Long-Term Care and partner ministries and communicated widely to ensure consistent implementation across the Province.

2.3. Existing Government Policies

It is recommended that the Ministry of Health and Long-Term Care reinforce existing forensic policies (The Distribution of Mental Health Forensic Beds in Ontario, Ontario Ministry of Health, 1998a; The Provincial Forensic System: Strategic Directions, Ontario Ministry of Health, 1997) and the recommendations in the inter-ministerial report, A Provincial Strategy to Coordinate Human Services and Criminal Justice System in Ontario (Human Services and Justice Coordination Project, 1997).

2.4. Information Needs for the Effective Management of the Forensic Mental Health System in Ontario

It is recommended that, in order to meet the immediate information needs to effectively manage the forensic mental health system in Ontario, the Minister of Health and Long-Term Care support the development and implementation of a Management Information System (MIS) specific to forensic services. This MIS may serve as the prototype for a MIS that would incorporate the broader mental health system. In addition, the inter-ministerial information required for a comprehensive MIS should be amalgamated with the broader mental health MIS. Therefore, three sub-recommendations are proposed.

2.4.1. Development of a Forensic Management Information System

It is recommended that the Minister of Health and Long-Term Care support the development of a stand-alone Forensic Management Information System (MIS) to meet the immediate regional and provincial need for useful, accurate and timely information to ensure the forensic mental health system in Ontario is well coordinated and is managed in a responsible manner fiscally, clinically and administratively.

2.4.2. Amalgamation of the Forensic Management Information System with the Broader Mental Health Management Information System

It is recommended that the Minister of Health and Long-Term Care support the interface of the Forensic Management Information System (MIS) with the planned broader Mental Health MIS to meet the regional and provincial need for useful, accurate and timely information on all forensic clients as they are integrated in non-forensic mental health programs as per Ministry policy.

2.4.3. Amalgamation of the Broader Mental Health Management Information System with Other Ministries' Management Information Systems

It is recommended that the Minister of Health and Long-Term Care support the interface of the planned broader, comprehensive Mental Health Management Information System (MIS) with other planned Ministries' (Ministry of the Attorney General, Ministry of Public Safety and Security and Ministry of Community, Family and Children's Services) MISs to meet the regional and provincial need for useful, accurate and timely information on all forensic clients whose complex needs involve several Ministries.

Information and Data

A need for a Management Information System (MIS) to address the day-to-day needs across forensic services in the Province in real time, including the identification of an efficient and effective information technology architecture that will have the capability of being integrated with a broader health / mental health and inter-ministerial monitoring and evaluation system.

3. CONCEPTS AND DEFINITIONS

3.1. Definition of a Forensic Client

It is recommended that the Ministry of Health and Long-Term Care adopt the definition of "forensic client" as a person who suffers from a major mental disorder, is in conflict with the law and is being dealt with by the courts or the Ontario Review Board under Part XX.1 - Mental Disorder of the Criminal Code (Canada).

3.2. When a Client Ceases to be a Forensic Client

It is recommended that the Ministry of Health and Long-Term Care adopt the definition as to when a "forensic client" ceases to be "forensic" when the individual is no longer subject to proceedings pursuant to Part XX.1 - Mental Disorder of the Criminal Code (Canada).

3.3. Definition of Designated Forensic Beds

It is recommended that the Ministry of Health and Long-Term Care adopt the definition of a "designated forensic bed" as a bed so defined and classified by Ministry of Health and Long-Term Care policy.

3.4. Definition of Protected / Integrated Forensic Beds

It is recommended that the Ministry of Health and Long-Term Care adopt the definition of a "protected / integrated forensic bed" as a bed outside of the Ministry designated forensic units / bed count that are occupied by forensic clients.

3.5. Standardized Risk Assessment

It is recommended that the Ministry of Health and Long-Term Care endorse a uniform standard for the assessment of risk for violent and / or sexual re-offending, that is comprised of the following 5 domains:

1. ***Bio / psycho / social History***
2. ***Assessment of Clinical (Dynamic) Risk***
3. ***Standardized assessment of anti-sociality / criminality***
4. ***Actuarial Assessment of Risk***
5. ***The Individual's Canadian Police Information Centre (CPIC) Record.***

3.5.1. Risk Management

It is recommended that the Ministry of Health and Long-Term Care endorse uniform protocols for risk management plans regarding forensic clients engaged in the community reintegration phase of their rehabilitation.

Concepts and Definitions

A need to articulate concepts and definitions as they relate to the forensic mental health system to ensure that these are understood consistently by individuals across ministries, professional disciplines and service providers.

4. SYSTEM CAPACITY AND INTEGRATION

4.1. Forensic Bed Ratio Policy

It is recommended that the Ministry of Health and Long-Term Care's forensic bed ratio policy be reinforced as a minimum ratio, with a focus on significantly enhancing community services, such as diversion, housing and intensive case management.

It is further recommended that the Ministry's forensic bed ratio be reviewed to determine whether the existing ratio of forensic beds per 100,000 adult population accurately reflects current need. Because population rates fluctuate, the issue of appropriate number of forensic beds will need to be reviewed every two years.

It is further recommended that the Ministry accepts the Panel's recommended ratios of 1.4 beds per 100,000 adults for designated long stay / maximum secure beds, 5.2 beds per 100,000 adults for designated regional secure beds and 3.0 for protected / integrated beds per 100,000 adult population.

4.2. Assertive Community Treatment Teams (ACTTs)

It is recommended that the Ministry of Health and Long-Term Care enforce the existing standards for the provision of forensic service by Assertive Community Treatment Teams, with a focus on implementation of the admission criterion for clients who are a high risk or have a recent history of criminal justice involvement (Recommended Standards for Assertive Community Treatment Teams, Ontario Ministry of Health, 1998b).

4.3. Case Management Services

It is recommended that the Ministry of Health and Long-Term Care make available a variety of case management services to the forensic population. These models of assertive case management services should be flexible in referral criteria and should provide a range of approaches, from an intensive case management model to an after care model.

4.4. Mental Health Court Support Services

It is recommended that the Ministry of Health and Long-Term Care address mental health court support services with respect to increasing resources and developing guidelines in terms of standard of practice, accountability and evaluation.

4.5. Forensic Client Integration

It is recommended that the Ministry of Health and Long-Term Care policy directing the principle of forensic client integration in non-forensic services (hospital and community-based) be enforced. Forensic clients at a lower security risk should be accommodated in "protected / integrated beds" located in other areas outside of a Regional Forensic Programs provided that forensic expertise is available on a consultative basis, that staff have appropriate information about the care and management of forensic clients and proper financial arrangements could be negotiated with the government. The Ministry should also firmly enforce the existing policy that a forensic designation is not grounds to refuse admission to a required service.

4.6. Balancing Forensic and Non-Forensic Resources

It is recommended that the Ministry of Health and Long-Term Care formulate a policy that addresses the necessity for achieving a balance between forensic and non-forensic inpatient and outpatient services provided by mental health facilities.

4.7. Responsibility of the Forensic System to Support the Mental Health System

It is recommended that the Ministry of Health and Long-Term Care endorse the concept that the forensic system, as an important part of the overall mental health system (including community programs), has a responsibility to make itself available to other parts of the mental health system, especially for consultations and educational activities.

4.8. Financial Resources for Forensic Programs and Services

It is recommended that the Ministry of Health and Long-Term Care ensure that an equitable funding formula be applied to each Regional Forensic Program.

4.9. Provincial Forensic Hospital

For purposes of economies of scale and critical mass of staff and resources, the Panel reaffirms the Ministry of Health and Long-Term Care's policy to have one Provincial Forensic Hospital in the Province and recommends the replacement of the outdated facilities in existence at the Mental Health Centre Penetanguishene, Oak Ridge Division, as soon as possible.

4.10. Repatriation of Forensic Clients within the Mental Health System

It is recommended that civilly committed offenders and Ontario Review Board (ORB) clients who are transferred to the Provincial Forensic Hospital from regional facilities due to management / treatment issues be repatriated in accordance with an agreed provincial protocol.

4.11. Impact of General Psychiatric Bed Availability on the Forensic System

It is recommended that the Ministry of Health and Long-Term Care make no further reduction in the availability of acute or long-term general mental health beds until there is a documented decrease in demand for those beds.

4.12. *Range of Forensic Services in Ontario* Document

It is recommended that the Ministry of Health and Long-Term Care adopt as policy the document entitled Range of Forensic Services in Ontario (Ontario Ministry of Health and Long-Term Care, 2002) and the associated recommendations developed by the Forensic Directors Group.

System Capacity and Integration

A need for all partner Ministries to work collaboratively in addressing the needs of common clients and to determine how best to achieve this as well as for Ministry of Health and Long-Term Care to implement forensic services in an effective, efficient and seamless manner within the mental health system.

5. INTER-MINISTERIAL ISSUES

5.1. Affordable Supportive Housing for the Seriously Mentally Ill Who are in Conflict with the Law

It is recommended that the Ministry of Health and Long-Term Care develop a range of affordable supportive accommodations to address the housing needs of seriously mentally ill individuals on dispositions, individuals with special needs who are in conflict with the law released on court order, individuals who are "fit" or "unfit" with trial pending and with no known address, individuals who are discharged from detention, and individuals who are on probation and / or court diversion.

5.2. Court Ordered Assessments

It is recommended that the Ministry of Health and Long-Term Care consider all court ordered assessments under Part XX.1 Criminal Code (Canada) as a direct support to the justice system and, therefore, funded by the justice system.

Following the mandate of Section 672.16, court ordered fitness assessments should be done out of hospital.

If a hospital setting is required, the order must provide for the immediate return of the client to the criminal justice system following the completion of the assessment.

Public hospitals must enhance their current role by providing services to low risk mentally disordered offenders and to seriously mentally ill persons at risk for criminal behaviour.

5.3. Management of Forensic Clients in an Integrated Inter-Ministerial System

It is recommended that the Ministry of Health and Long-Term Care, in partnership with affected Ministries, support that, when clients move from one system to another, such as from the correctional system to the mental health or social services systems and vice versa, "follow-up" case workers from the host / sending facilities liaise with them to enhance continuity of care and public safety while reducing victimization.

5.4. Crown Policy on Mental Health Diversion

It is recommended that Crown policy on mental health diversion be reviewed and revised in consultation with representatives of Mental Health Court Support Services, Ministry of Health and Long-Term Care, Ministry of the Attorney General, Ministry of Community, Family and Children's Services, community mental health agencies providing the service, individuals who are developmentally disabled, victims of acquired brain injury, consumer survivors and other appropriate stakeholders.

5.5. Police Diversion for Persons with Mental Illness (Pre-charge Diversion)

It is recommended that the Ministry of Health and Long Term Care, in conjunction with the Ministry of the Attorney General and the Ministry for Public Safety and Security, develop provincial educational / training guidelines and programmes for police officers in relation to diverting persons with mental illness, where accused of committing minor offences, from the criminal justice system.

Provincial directives between the Schedule 1 facilities and the Local Police Services must be established and maintained.

5.6. Use of Telecommunications for Forensic Assessments

In order to expedite assessments, make better use of clinical personnel and decrease potentially unnecessary admissions to the Regional Forensic Programs and the Provincial Forensic Hospital, it is recommended that the Ministry of Health and Long-Term Care, in concert with the Ministry of the Attorney General, explore a system of telehealth / telelaw connecting both remand centres and court systems to the Regional Forensic Programs and the Provincial Forensic Hospital.

5.7. Impact of Provincial Correctional Facilities on the Mental Health System

It is recommended that the Ministry of Health and Long-Term Care and the Ministry of Public Safety and Security jointly develop a provincial protocol regarding the manner in which inmates of provincial correctional facilities access provincial and regional mental health resources and how they are linked into services in their home communities at the end of their sentences.

Due to recent proposed changes in how the Ministry of Health and Long-Term Care and the Ministry of Public Safety and Security will be managing the provision of mental health services to inmates in provincial correctional facilities, a provincial protocol is required to establish the roles and responsibilities of both parties.

5.8. Special Populations

In keeping with the roles and responsibilities articulated in the Human Services and Justice Coordination Project (1997), it is recommended that each of the partner Ministries formally acknowledge and accept their roles and responsibilities to establish and resource the necessary treatment capacity and support systems for their special target populations.

5.9. Special Role of the Crown Prosecutor

It is recommended that the Ministry of Health and Long-Term Care provide educational resources to support the Ministry of the Attorney General in its provision of sufficient resources to the prosecution service in the Province of Ontario to ensure that specially trained Crown prosecutors with sufficient knowledge and skill to address the needs of mentally disordered accused persons and offenders are available in each Crown Attorneys Office.

5.10. Cultural Diversity

It is recommended that the criminal justice and forensic mental health systems:

- *incorporate policies and practices that respect the diverse needs of individuals of different races and cultures;*
- *allocate sufficient resources to meet the needs of this population; and*
- *consult with appropriate agencies or other resources to provide education and training on cultural sensitivity which will impact on organizational changes and the delivery of treatment and services.*

Inter-ministerial Issues

A need to identify and address common issues across Ministries, namely, Ministry of the Attorney General (MAG), Ministry of Health and Long-Term Care (MOHLTC), Ministry of Community, Family and Children's Services (MCFCS), and Ministry of Public Safety and Security (MPSS).

A. VISION FOR THE FORENSIC MENTAL HEALTH SYSTEM IN ONTARIO

The provincial forensic system will be comprised of a strong inter-ministerial partnership that will provide services and supports that are fully integrated, accountable, effective and coordinated to meet the needs of the seriously mentally ill who come in contact with the law and the service continuum will provide equitable and stream-lined access to quality care and allow clients to live in the community, to the greatest extent possible.

The provision of efficient and effective services to ensure that Ontario's mental health system best meets the needs of all people with serious mental illness is integral to Mental Health Reform. The reformed mental health system includes people, commonly identified as forensic clients, who have multiple and complex overlapping needs relating to aggression, legal status and clinical / risk management.

Due to the nature of these multiple and complex needs, health, social service and judicial systems work cooperatively to meet the Ministries' shared goals of achieving healthy and safe communities and recognize that solutions are a joint responsibility.

A well-coordinated, appropriately-resourced and clearly articulated comprehensive long-range plan for the delivery of services for Mentally Disordered Offenders (MDO) ensures improved quality of service and quality of life for these clients, enhances public safety, and increases service / systems efficiencies. These services are delivered through a continuum of care from highly specialized client care to informal community supports.

Forensic mental health services must be provided efficiently and effectively

Health, social service and judicial systems must work together to meet Ministries' shared goals

Long range plan for delivery of forensic mental health services enhances quality of services, quality of life for clients, public safety and systemic efficiencies

B. MANDATE

In January 2001, the Ontario Minister of Health and Long-Term Care established a Forensic Mental Health Services Expert Advisory Panel to consider province-wide operational issues in the context of existing policies and information and to advise government on a provincial strategy for implementation of forensic mental health services, specifically:

- Inter-ministerial coordination of forensic services;
- Consolidation and clarification of existing Ministry of Health and Long-Term Care (MOHLTC) forensic policy; and
- Processes to improve services for forensic clients.

Panel was established to review province-wide operational issues and to advise government on a provincial strategy on implementation of forensic mental health services

The Panel was mandated to advise the Minister on the implementation and integration of forensic systems within mental health reform as set out in *Making It Happen* (Ontario Ministry of Health, 1999) and related documents, including *The Distribution of Mental Health Forensic Beds in Ontario* (Ontario Ministry of Health, 1998a), *The Provincial Forensic System: Strategic Directions* (Ontario Ministry of Health, 1997) and the recommendations in the inter-ministerial report, *A Provincial Strategy to Coordinate Human Services and Criminal Justice System in Ontario* (Human Services and Justice Coordination Project, 1997).

C. INTRODUCTION

Forensic mental health services include the assessment, management and treatment of mentally disordered persons in conflict with the law. Until February 1992, serious mentally disordered offenders were subject to the insanity provisions in the *Criminal Code (Canada)*. In 1992, the insanity provisions were repealed and replaced with Part XX.1 of the *Code*. The amendments in Part XX.1 extended the application of the *Code's* mental disorder provisions to less serious summary conviction offences and significantly extended the ability of courts to access mental health services based on the needs of the criminal justice system rather than clinical assessments of the accused person's condition.

Forensic mental health services include the assessment, management and treatment of mentally disordered persons in conflict with the law

Number of forensic clients has steadily increased over the past several years

Demand exceeds supply for forensic beds and services

The number of forensic clients has steadily increased over the past several years. This trend has resulted in an increase in demand for forensic services. This increase was predicted in a provincial forensic survey titled *Forensic Psychiatric Clients in Ontario* (Rice, Harris, Cormier, Lang, Coleman, & Krans, 1999). The exponential increase in forensic bed demand and utilization was also predicted to have a significant impact on the availability of mental health beds for civilly committed clients. Although there has been an increase in forensic beds and services provincially (e.g., 97 additional forensic beds since 1995, court diversion, a Mental Health Court), the demand exceeds supply for forensic beds and services. For example, since a *habeas corpus* application was brought in 1998 which resulted in all clients with Ontario Review Board (ORB) Dispositions being transferred from jails and detention centres to their respective designated hospitals, the number of clients with Dispositions waiting for hospital beds has increased again. The lack of treatment options in jails, increased use of the health system by the courts, the segregation of forensic clients in health care facilities and the criminalization of the mentally ill also contribute to the increasing demand for forensic services. The criminalization of the mentally ill has also resulted in decreasing numbers of mental health beds being available to civil clients.

D. ISSUE IDENTIFICATION

The Panel has identified many barriers to the successful implementation of the existing Ministry policies and the effective management of the forensic system in the Province of Ontario (refer to the Panel's *Interim Report* in Appendix A), including, but not limited to, the following (not prioritized):

The Panel has identified at least 13 major barriers to the successful implementation of existing Ministry policies and the effective management of the forensic system

1. A lack of co-ordination and accountability for how institutional mental health services are accessed and used by the criminal justice system. The demand for mental health services by the criminal justice system often is based on the needs of the criminal justice system rather than the needs of the mentally ill, particularly since 1992 when the insanity provisions were repealed and replaced with Part XX.1 of the *Criminal Code (Canada)* (Watt & Fuerst, 2002).

2. An overuse of mental health services by the criminal justice system where the courts order multiple assessments, particularly for fitness to stand trial.

3. The use of secure forensic beds for clients who could be managed in less secure settings, the general mental health

system or the community. This problem, in part, results from the refusal of some components of the mental health system to accept forensic clients. This runs counter to government policy (*Making It Happen*, Ontario Ministry of Health, 1999) of "integrating lower-risk forensic clients into broader mental health services" (p. 56) and forensic policies (*The Distribution of Mental Health Forensic Beds in Ontario*, Ontario Ministry of Health, 1998a; *The Provincial Forensic System: Strategic Directions*, Ontario Ministry of Health, 1997).

4. A lack of relevant triage systems at the court level so that clients could be diverted from the justice system where appropriate, including the need to have a mechanism that allows individuals who are the most in need (most dysfunctional and ill) to access the beds first.

5. A poor understanding of definitions and forensic issues by individuals across ministries, professional disciplines and service providers. There is a need to develop definitions that are understood and endorsed by those involved in the field of forensic mental health.

6. The stigmatization of mental health clients once they are labeled "forensic". An individual who acquires the "forensic" label is severely compromised in his / her ability to access opportunities (e.g., employment, housing) normally available to civilly committed clients and the general population. This stigmatization has had a direct impact on the lack of appropriate accommodation in the community for forensic clients who might otherwise be discharged from hospital.

7. The refusal by many mental health agencies to accept forensic clients is contrary to Ministry of Health and Long-Term Care policy. Clinical staff in general psychiatric units often feel that individuals who need hospitalization and are involved with the criminal justice system should be hospitalized in a forensic bed. General community psychiatrists are sometimes reluctant to accept referrals if the individual is before the courts for fear of having to testify, write lengthy reports, or liability concerns.

8. Access to long-term community supports is extremely difficult for forensic clients. Criteria for acceptance by community services (e.g., Assertive Community Treatment Teams) are too restrictive and response to referrals is too long.

Major barriers include:

- lack of co-ordination and accountability for how forensic mental health services are utilized by the criminal justice system
- overuse of mental health services by the criminal justice system
- misuse of secure forensic beds
- lack of relevant triage systems at the court level
- poor understanding of definitions and forensic issues
- stigmatization of forensic clients
- refusal by many mental health agencies to accept forensic clients
- limited access to long-term community supports
- limited community alternatives for less serious mentally disordered offenders
- inadequate planning and services for mentally ill clients in the correctional system
- inadequate resources for mental health court support services
- insufficient senior ministry support
- no provincial coordinating body to manage the forensic system

9. There are limited community alternatives for less serious mentally disordered offenders who might otherwise be diverted from the criminal justice system. The use of the mental health system by the courts and others in the criminal justice system to address the perceived social needs of persons in conflict with the law is problematic. Police need a third option besides arrest and hospitalization. There is not enough emphasis on pre-charge diversion and prevention based on accepted standards of practice.

10. There is inadequate pre-release planning for mentally ill clients from the correctional system and inadequate post-release community care by the Ministry of Public Safety and Security (MPSS). Many inmates who suffer from a severe mental illness are re-integrated in the community without establishing links with community mental health services and supports. The consequence is that these individuals end up requiring a mental health bed or re-enter the forensic stream.

11. There are inadequate resources for mental health court support services. The service demand volume within these programs is very high (especially in large urban areas).

12. There is insufficient senior ministry support from the Ministry of the Attorney General (MAG), Ministry of Health and Long-Term Care (MOHLTC), Ministry of Community, Family and Children's Services (MCFCS), and Ministry of Public Safety and Security (MPSS) to enforce adherence to existing policies and oversee system change implementation.

13. There is no provincial coordinating body with a mandate to effectively direct adherence to existing / approved inter-ministerial forensic policies and procedures.

E. STRATEGIC DIRECTION

The Panel has:

- Compiled a considerable number of documents pertaining to the development and deployment of forensic resources across the Province;
- Reviewed the extant forensic policies and data from a number of different forensic services and best practice models in several of these services; and
- Reviewed several other related documents, including government position papers and initiatives.

Based on this large volume of material, the Panel identified five categories of issues:

1. **Leadership and Accountability:** A need for a central provincial administrative structure to monitor and manage forensic issues systematically and to shape the development of forensic mental health services.
2. **Information and Data:** A need for a Management Information System (MIS) to address the day-to-day needs across forensic services in the Province in real time, including the identification of an efficient and effective information technology architecture that will have the capability of being integrated with a broader health / mental health and inter-ministerial monitoring and evaluation system.
3. **Concepts and Definitions:** A need to articulate concepts and definitions as they relate to the forensic mental health system to ensure that these are understood consistently by individuals across ministries, professional disciplines and service providers.
4. **System Capacity and Integration:** A need for all partner Ministries to work collaboratively in addressing the needs of common clients and to determine how best to achieve this as well as for Ministry of Health and Long-Term Care to implement forensic services in an effective, efficient and seamless manner within the mental health system.
5. **Inter-ministerial Issues:** A need to identify and address common issues across Ministries, namely, Ministry of the Attorney General, Ministry of Health and Long-Term Care, Ministry of Community, Family and Children's Services, and Ministry of Public Safety and Security.

Panel has identified 5 categories of issues:

- Leadership and Accountability
- Information and Data
- Concepts and Definitions
- System Capacity and Integration
- Inter-ministerial Issues

F. RECOMMENDATIONS

Based on a review of the aforementioned five categories of issues, the Panel generated a number of recommendations for each category for the Minister's consideration.

1. LEADERSHIP AND ACCOUNTABILITY

1.1. LOCAL AND REGIONAL FORENSIC HUMAN SERVICES AND JUSTICE COORDINATING COMMITTEES

Background

The Ontario government's policy framework for people with clinical needs who come in conflict with the law *A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario* was approved in 1997 (Human Services and Justice Coordination Project, 1997). This policy identifies forensic clients and individuals with severe criminogenic and clinical needs as "common clients" and proposes a model of shared responsibility and accountability in dealing with these individuals. Each of the service sectors (police, corrections, courts, mental health and developmental services) need to understand client needs and issues, the respective roles and contributions of the various agencies and public safety requirements.

Human Services and Justice Coordinating Committees are essential to the model of shared responsibility and accountability

The primary goal of the coordinating committees is to facilitate cross-sector service coordination in response to client needs

Because a system of care for forensic clients contains elements from five separate service systems, the primary goal of Human Services and Justice Coordinating Committees is to facilitate cross-sector service coordination in response to client needs, and identify and address issues such as access to and duplication of services. The coordinating committees are expected to take action to resolve cross-sector coordination and linkage issues. Where issues of access, duplication or coordination arise primarily within one service sector, the coordinating committees will play regional advisory and facilitative roles with follow-up action also requiring Ministry program area participation and direction. In all cases, committees will start coordinated service delivery to develop a pragmatic blueprint for action. These coordinating committees will liaise primarily with the regional offices of the various Ministries.

To enable this service coordination to occur across the mental health, developmental services and justice systems, the provincial strategy must recognize the need to formalize the collaborative processes through community services agreements, inter-agency working agreements, information-sharing protocols and joint educational initiatives. These collaborative processes include:

- agreements and protocols for diversion;
- community release plans under bail supervision, probation, or conditional discharge;
- criteria for priority admissions to forensic beds;
- institutional treatment in correctional facilities; and
- risk assessment.

Human Services and Justice Coordinating Committees' effectiveness has already been demonstrated

Ministry of Health and Long-Term Care to take a leadership role with partner Ministries to fund and establish the Coordinating Committees

The coordinating committees have demonstrated the effectiveness of developing a collaborative working relationship among the mental health, social services and the criminal justice systems. They have also developed a number of best practices with respect to providing services to common clients, which includes public education, crisis intervention protocols, fitness clinics in jails, court diversion, development of a mental health court, discharge planning and staff training. These evidence based / best practices provide benchmarks for implementation of key strategies in a reformed system of mental health care for persons with serious mental health needs that are involved in, or are in danger of becoming involved in, the criminal justice system.

District Health Councils have played a leadership role in facilitating the establishment of coordinating committees in various locations across the Province. Membership in the committees includes representatives from the judiciary, Crown attorneys, police, correctional services, mental health services, developmental services and consumers. In the Province to date, 22 coordinating committees have been identified and are in various stages of development.

RECOMMENDATION 1.1

It is recommended that the four partner Ministries (Ministry of Health and Long-Term Care, Ministry of Community, Family and Children's Services, Ministry of Public Safety and Security, Ministry of the Attorney General), with the Ministry of Health and Long-Term Care being the lead Ministry, equally endorse and fund the establishment of local and regional forensic coordinating committees, a key mechanism as per the inter-ministerial report, A Provincial Strategy to Coordinate Human Services and Criminal Justice System in Ontario (Human Services and Justice Coordination Project, 1997).

It is further recommended that a formal commitment be made by each of the four Ministries to recreate the Provincial Coordinating Committee to provide support and oversee the work of the Human Services and Justice Coordinating Committees throughout the Province. Local and Regional Human Services and Justice Coordinating Committees must liaise with the Ministry of Health and Long-Term Care as the lead Ministry.

1.2. ORGANIZATION OF MENTAL HEALTH SERVICES

Background

The twenty key junctures identified by the inter-ministerial report, *A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario* (Human Services and Justice Coordination Project, 1997), provide a good policy framework for intervention. However, implementation has been inadequate.

Proper implementation and funding of the key junctures would reduce the number of forensic clients in the system and would reduce recidivism rates.

Implement the 20 Key Junctures identified as inter-ministerial policy framework to reduce the number of forensic clients and recidivism

Implementation will require that the description of the key junctures be simplified and disseminated to the Ministries and organizations identified in the report.

Some of the critical aspects of the key junctures are prevention, pre-arrest and post-arrest diversion, court liaison, and treatment in correctional facilities. These critical aspects are addressed by other recommendations of the Forensic Mental Health Services Expert Advisory Panel in this *Final Report*. Nevertheless, it remains important to ensure that the purpose and effect of the initiatives are well understood by the participating Ministries and organizations.

A strong, inter-ministerial policy framework is necessary to ensure that the needs of mentally ill offenders are being met by the mental health, developmental services and justice systems.

Endorsement of this recommendation will provide a framework for the organization of mental health services.

RECOMMENDATION 1.2

It is recommended that the Ministry of Health and Long-Term Care simplify and disseminate the 20 key junctures from the inter-ministerial report, A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario (Human Services and Justice Coordination Project, 1997), and organize forensic mental health services in accordance with these 20 key junctures.

1.3. PROVINCIAL ADMINISTRATION OF FORENSIC MENTAL HEALTH SERVICES

Background

Some form of central provincial administrative structure is required to effectively monitor and manage forensic issues and shape the development of forensic mental health services. Regional Forensic Programs (programs that provide regional forensic services within each of the 9 hospitals designated by the Minister of Health and Long-Term Care for the Province for the custody, treatment or assessment of an accused in respect of whom an assessment order, or a disposition, or a placement decision is made; these services have historically been referred to as "medium" and "minimum" secure units / wards) and the Provincial Forensic Hospital (a hospital designated by the Minister of Health and Long-Term Care for long-stay / maximum secure use) require some degree of co-ordination and integration of their services. The co-ordination and integration of these services is important especially for matters pertaining to the Ontario Review Board, a quasi-judicial body charged with administration of Part XX.1 of the *Criminal Code (Canada)* having to do with Mental Disorder (Watt & Fuerst, 2002).

Every divested designated hospital must enter into an agreement with the Ministry (or eventual regional governance structure) concerning its provision of forensic mental health services. These agreements cover budgetary arrangements, protection of the forensic funding envelope, and a client transfer and dispute resolution mechanism. It is imperative that these agreements reflect some degree of consistency across the Province, in accordance with the recommendations contained in the document *Range of Forensic Services in Ontario* (Ontario Ministry of Health and Long-Term Care, 2002; refer to Appendix B).

Formal agreements are required to provide consistent service to forensic clients throughout the Province

A central provincial administrative structure is required to effectively manage the forensic mental health system

Effective inter-ministerial coordination is required

A central provincial administrative structure that must have direct influence over the provision of forensic services (rather than merely serving as an advisory body) is required to ensure equality of client care across the Province, fiscal responsibility, and support for the administration of health services and the provision of justice.

The courts and the Ontario Review Board determine admission of clients into the forensic mental health system. Discharge of clients from the forensic mental health system is determined by decisions of the Ontario Review Board, availability of housing and other health and social services, and access to care within the general mental health care system. Therefore, flow of clients through the forensic mental health system requires active coordination with government agencies and services outside the forensic mental health system, outside mental health services, and outside the ambit of the Ministry of Health and Long-Term Care. As a result, the central provincial administrative structure must have effective working relations with, or active membership from, all involved Ministries.

A central provincial administrative structure to oversee forensic mental health services is required to:

- protect the funding envelope;
- achieve inter-ministerial coordination to ensure effective service to common clients;
- develop forensic mental health policy;
- set standards of care in forensic mental health;
- conduct ongoing program evaluations; and
- integrate forensic mental health services with the general mental health system.

There is a need for guidelines, policies, service function descriptions and funding structures within and across the regions. These should facilitate accountability and the provision of services in line with principles of reintegration, normalization, continuation and seamless services as articulated in *Making It Happen* (Ontario Ministry of Health, 1999).

Decentralization of the management of forensic mental health services in the Province has made it increasingly more difficult to coordinate the management of forensic clients

The necessity for a central provincial administrative structure for forensic mental health services in the Province has significantly increased as a direct result of the divestment of 6 Provincial Psychiatric Hospitals (PPHs) and the eventual divestment of the remaining 4 PPHs from the direct operation by the Ministry of Health and Long-Term Care to a public hospital governance structure. The resulting decentralization of the management of forensic mental health services in the Province has made it increasingly more difficult to coordinate the management of forensic clients who are under the jurisdiction of the Ontario Review Board.

Endorsement of this recommendation will help to ensure the coordination and integration of effective forensic mental health services in the Province of Ontario.

RECOMMENDATION 1.3

It is recommended that the Minister of Health and Long-Term Care, in partnership with the Ministry of the Attorney General, Ministry of Public Safety and Security, and Ministry of Community, Family and Children's Services, establish a visible and recognizable central administrative structure to manage and co-ordinate the forensic mental health system in the Province as an integrated and critical part of the general mental health treatment system.

1.4. TRAINING OF SPECIALIZED CLINICIANS, RECRUITMENT, RETENTION AND FORENSIC RESEARCH

Background

The number of forensic mental health clients within the Ontario health care system has been steadily growing and, since the enactment of Bill C30 in 1992, growing rapidly. Forensic mental health clients often present with complex clinical problems that, if not effectively treated / managed, can lead to violence against others.

There is a need to increase the number of specialized forensic clinicians to match the increasing number of forensic clients

Collaborative initiatives are required to attract more individuals to the field of forensics

Consequences of treatment failure can be catastrophic for the client and the community and may result in adverse publicity for the forensic mental health system and the government. Timely and effective treatment of forensic clients' mental health issues and appropriate management of their risk to public safety requires highly specialized forensic clinicians. As the number of forensic mental health clients and the number of dedicated forensic beds increase, so does the demand for specialized forensic clinicians. A strategy is required to attract more students and established clinicians to the practice of forensic psychiatry and related clinical disciplines. Such a strategy requires collaborative initiatives involving the Ministry of Health and Long-Term Care, Ontario Hospital Association, Ontario College of Physicians and Surgeons, University Health Sciences faculties, Canadian Academy of Psychiatry and the Law, and others. Such strategies might include the recognition of forensic psychiatry as an under-resourced specialty (by the licensure of out-of-province specialists), the recognition of certain regions as under-resourced specifically (e.g., by an increased stipend), and by establishing a system of scholarships, fellowships and training programs. Remuneration of clinicians engaged in this challenging work within the public (institutional) sector must be reviewed in light of opportunities available to the same clinicians within the private sector.

It is important to recognize Forensic Psychiatry as an under-resourced specialty

Forensic programs must affiliate with recognized university Divisions of Forensic Psychiatry and establish relationships with programs for the training of Allied Health Professionals

A province-wide forensic research network must be developed

Regional Forensic Programs and the Provincial Forensic Hospital must be affiliated with recognized university Divisions of Forensic Psychiatry, or their equivalents, having joint responsibility for identifying best practices, educating professionals (health, legal, correctional) in forensic mental health specialization and conducting forensic research on topics such as epidemiology of crime, impact of stigmatization, biology of violence, risk assessment, and paraphilias (sexual behaviours).

Regional Forensic Programs and the Provincial Forensic Hospital must endeavour to establish relationships with programs for the training of Allied Health Professionals (e.g., Psychologists, Nurses, Social Workers, Occupational Therapists). Each Regional Forensic Program and the Provincial Forensic Hospital will contribute to a forensic database for research purposes. The database will be consistent across all Regional Forensic Programs and the Provincial Forensic Hospital and provide part of a research network in forensic mental health services for the Province of Ontario. Research will include a focus on risk assessment, risk management, and ongoing clinical needs assessment in relation to dedicated forensic mental health programs. Treatment outcome measures, treatment programs and protocols must be in place in the different designated hospitals that will facilitate best practices and promote the integration of research findings into practice. Each Regional Forensic Program and the Provincial Forensic Hospital must have representation on a Provincial Forensic Research Committee to review proposals and make recommendations that involve more than one region.

Endorsement of this recommendation will facilitate an increase in the number of persons pursuing a career in forensic mental health as a specialty and, thereby, ensure continued quality, timely, effective treatment and risk management practices within the forensic mental health system in Ontario.

RECOMMENDATION 1.4

It is recommended that the Ministry of Health and Long-Term Care support an initiative, under the leadership of representatives from the Academic Health Sciences Programs in Ontario, for the design and implementation of an effective program to facilitate an increase in the number of specialty trained forensic clinicians in the mental health system in Ontario.

1.5. PANEL TO MEET WITH MINISTRY OF HEALTH LONG-TERM CARE REPRESENTATIVES

Background

Panel members have invested much time, effort and expertise in their consideration of province-wide operational issues in the context of existing policies resulting in 40 recommendations in this *Final Report*. The Panel members are committed to assisting the Minister of Health and Long-Term Care, as appropriate, by offering their services to reconvene to discuss with Ministry representatives the status, implementation strategies and any outstanding operational and policy issues stemming from the Panel's *Final Report* and its concomitant recommendations.

Forensic Mental Health Services Expert Advisory Panel should reconvene

RECOMMENDATION 1.5

It is recommended that the Minister of Health and Long-Term Care invite the Panel to reconvene in the Fall of 2003 and annually thereafter to discuss with Ministry representatives the status, implementation strategies and any outstanding operational and policy issues stemming from the Panel's Final Report and its concomitant recommendations.

2. INFORMATION AND DATA

2.1. DEVELOPMENT OF A FORENSIC POLICIES AND PROCEDURES MANUAL

Background

The Ministry of Health and Long-Term Care needs to develop a "forensic policies and procedures manual" that would ensure consistency in the delivery of regional forensic mental health services throughout the Province of Ontario.

Given the large volume of material and complexity of issues, there appears to be a lack of standardization in the policies and practices that are currently in place and administered throughout the regions of the province. Similarly, a review of inter-ministerial documents and policies revealed that there is a lack of provincial co-ordination and accountability for how institutional mental health services are accessed and used by the criminal justice system. The Ministry of Health and Long-Term Care should reinforce existing forensic policies (*The Distribution of Mental Health Forensic Beds in Ontario*, Ontario Ministry of Health, 1998a; *The Provincial Forensic System: Strategic Directions*, Ontario Ministry of Health, 1997) and the recommendations in the inter-ministerial report, *A Provincial Strategy to Coordinate Human Services and Criminal Justice System in Ontario* (Human Services and Justice Coordination Project, 1997). There also appears to be a poor understanding of definitions and forensic issues by individuals across ministries, professional disciplines and service providers. There is a need to develop definitions that are understood and endorsed by those involved in this field. Furthermore, it is noted that, because of this lack of documented standardization, there has been insufficient senior Ministry (Ministry of the Attorney General, Ministry of Health and Long-Term Care, Ministry of Community, Family and Children's Services, Ministry of Public Safety and Security) support to enforce adherence to existing policies and to oversee system change implementation. Pursuit of some form of documented standardization may ensure consistency in application across the Province and should include the creation of a coordinating body with a provincial mandate to effectively direct adherence to inter-ministerial forensic policies and procedures.

Provincial standardization of inter-ministerial policies and procedures is necessary to ensure consistency of application

Endorsement of this recommendation will help to ensure the coordination and integration of effective forensic mental health services in the Province of Ontario.

RECOMMENDATION 2.1

It is recommended that the Ministry of Health and Long-Term Care, in partnership with the Ministry of the Attorney General, Ministry of Public Safety and Security, and Ministry of Community, Family and Children's Services, develop a Forensic Policies and Procedures Manual to ensure consistency in the delivery of forensic services across Regional Forensic Programs throughout the Province of Ontario.

2.2. A COMPREHENSIVE PLAN FOR A COORDINATED PROVINCIAL FORENSIC SYSTEM MUST BE DEVELOPED AND COMMUNICATED

Background

In May 2002, the Forensic Directors Group provided the Panel with a document entitled *Range of Forensic Services in Ontario* (Ontario Ministry of Health and Long-Term Care, 2002). This document included a number of recommendations for consideration by the Panel and the Ministry of Health and Long-Term Care.

Organize forensic reports submitted into a comprehensive plan to facilitate the coordination and integration of effective forensic mental health services in Ontario

In the last 10 years, mental health experts in Ontario have dedicated a tremendous amount of time and energy to generating a variety of insightful and helpful reports. Many of these reports contain recommendations with common elements with which most (if not all) of the parties involved in the forensic services system agree. Implementation of the recommendations contained within these documents will be difficult (if not impossible) without organizing these documents to form a comprehensive plan, which would then need to be sanctioned by the Ministry of Health and Long-Term Care and partner Ministries. Such a plan would allow all parties involved in forensic mental health services to move in a common direction, and would have the added benefit of facilitating the implementation of many of the other recommendations of the Panel (e.g., recommendations regarding the implementation of a province-wide Management Information System).

Support for this recommendation will facilitate the coordination and integration of effective forensic mental health services in Ontario.

RECOMMENDATION 2.2

It is recommended that all forensic documents that have contributed to provincial forensic policy be coalesced to develop a comprehensive plan for a coordinated provincial forensic system for the Province. The resultant policy document must be sanctioned by the Ministry of Health and Long-Term Care and partner Ministries and communicated widely to ensure consistent implementation across the Province.

2.3. EXISTING GOVERNMENT POLICIES

Background

The Provincial Forensic System: Strategic Directions (1997a) and T*he Distribution of Mental Health Forensic Beds in Ontario* (Ontario Ministry of Health, 1998a), adopted as policy by the Ministry of Health and Long Term-Care, in conjunction with *A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario* (Human Services and Justice Coordination Project, 1997), have served as the cornerstone for the forensic mental health services in the Province. The policies all share a common vision for people with clinical needs and who are in conflict with the law that is consistent with the major theme driving a number of other government initiatives. Each policy builds on the other. The effectiveness of the Ministry of Health and Long-Term Care's forensic bed distribution strategy (Ontario Ministry of Health, 1998a) relies on the successful implementation of the recommendations of the Human Services and Justice Coordination Project (1997). An effective and efficient forensic system would rely on the availability of

Ministry of Health and Long-Term Care has developed a strategic direction for provision of dedicated and integrated forensic mental health services adequate beds and all the other measures in place to prevent mentally disordered persons from becoming forensic clients.

In the discussion paper *Rebuilding Ontario's Health System: Interim Planning Guidelines and Implementation Strategies* (Ontario Ministry of Health, 1997b), the Health Services Restructuring Commission stated with respect to forensic mental health services: "Considerable concern has been expressed about the insufficient supply of forensic beds available provincially by the Ontario Review Board and other service providers. Additionally, clients often wait several months in jail before accessing a forensic bed."

Ministry of Health and Long-Term Care has existing policy for a provincially-coordinated forensic mental health system and protected resources to serve forensic clients

The Ministry of Health and Long-Term Care has adopted strategic directions for the forensic system (*The Provincial Forensic System: Strategic Directions*, Ontario Ministry of Health, 1997a). Central components of this strategy include the establishment of a provincially-coordinated, dedicated forensic mental health system (comprised of a Provincial Forensic Hospital and Regional Forensic Services) and a protected stream of general mental health resources to serve forensic clients in integrated mental health settings. The goals of inter-ministerial and forensic mental health policy are:

- to decriminalize people with mental illness who come in conflict with the law;
- to prevent, where possible, antisocial behaviour arising from mental illness through the provision of appropriate community supports;
- to treat forensic clients as close to home as possible and economically feasible; and
- to integrate low risk forensic clients with the general mental health population.

The provincial mental health system must provide both dedicated and integrated forensic mental health services. Dedicated forensic services should primarily serve people who require treatment or assessment in secure custody, or special conditions of supervision in an open setting or the community because of their violent, dangerous or criminal propensities. Other forensic clients should be treated and supervised through general mental health services (community mental health agencies and local

Schedule 1 facilities) that will have access to support and consultation through the specialized Regional Forensic Programs.

Expectations of Ontario's forensic mental health system include the following:

- forensic mental health services should function as part of a coordinated system involving psychiatric hospitals designated under the *Criminal Code (Canada)* (Watt & Fuerst, 2002), other hospital services, and a network of independent clinicians and community mental health services;
- forensic mental health services will provide a continuum of care (assessment, treatment, rehabilitation, security management, community supervision, consultation and support) within functionally defined levels of security, ranging from maximum secure to community supervision;
- a cascading system whereby clients move easily to progressively lower or higher levels of security, or into integrated settings that match their current level of risk and treatment need;
- a system balancing economies of scale with the need to concentrate expertise in a single center through the provision of a Provincial Forensic Hospital and Regional Forensic Programs proportionate to the population base of the region;
- point of entry and point of discharge coordination from the hospital system, as well as between health and other government systems.

Expectations of Ontario's forensic mental health system is clearly articulated in Ministry of Health and Long-Term Care policies

The Ministry of Health and Long-Term Care's *Strategic Directions* policy document (Ontario Ministry of Health, 1997a) accepts that to fulfill these roles, the allocation of regional services (including Regional Forensic Programs) should be proportionate to the population base of the region. Further, sufficient resources should be allocated to meet the needs of forensic clients and provide appropriate specialized forensic mental health services in courts and correctional facilities in Ontario. Waiting lists should be minimized and access to services be timely.

Ontario's government policy framework is based on a vision that is dramatically different from the way Ministry systems currently operate

The Ontario government's policy framework for people with clinical needs who come in conflict with the law, *A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario* (Human Services and Justice Coordination Project, 1997), was approved in June 1997. This government policy identifies current forensic clients and individuals with severe criminogenic and clinical needs as 'common clients' (between the relevant Ministries) and proposes a model of shared responsibility and accountability in dealing with these individuals. The government policy document outlines a vision that is dramatically different from the way Ministry systems currently operate. Everyone (service providers, police, court and correctional officials, clients and families, community representatives) is to be involved in designing creative solutions that contribute to the shared goals of achieving healthy and safe communities. Expected outcomes include improved quality of service and quality of life for clients, enhanced public safety, and increased service / systems efficiencies within current global spending.

Implementation of the provincial forensic strategy and coordination protocols requires changes in knowledge, attitudes and behaviours. Knowledge, particularly concerning the application, generation, and processing of risk and clinical needs information, is essential for effective work performance. Attitudes that support the shared responsibility model for common clients include creativity, flexibility, responsiveness and cooperation. These in turn should lead to the following changes in systems behaviour:

Implementation of the provincial forensic strategy and coordination protocols requires changes in knowledge, attitudes and behaviours

- prevention will be facilitated through the provision of on-going supports and continuity of care; service providers will keep in touch with their clients, even where legal jurisdiction passes over to another organization;
- clients will not be 'dumped' on other systems;
- providers will jointly plan and deliver services, as well as exchange information;
- intensive resources will be targeted to clients with significant needs; and

- every stakeholder will have a responsibility for effective resource utilization, and organizations will commit to joint funding or creative financing to develop innovative new services.

RECOMMENDATION 2.3

It is recommended that the Ministry of Health and Long-Term Care reinforce existing forensic policies (The Distribution of Mental Health Forensic Beds in Ontario, Ontario Ministry of Health, 1998a; The Provincial Forensic System: Strategic Directions, Ontario Ministry of Health, 1997a) and the recommendations in the inter-ministerial report, A Provincial Strategy to Coordinate Human Services and Criminal Justice System in Ontario (Human Services and Justice Coordination Project, 1997).

2.4. INFORMATION NEEDS FOR THE EFFECTIVE MANAGEMENT OF THE FORENSIC MENTAL HEALTH SYSTEM IN ONTARIO

Background

Timely access to accurate and reliable data is fundamental for the efficient and effective management of the forensic mental health system in Ontario. Historically, forensic data were transferred on diskettes from each Provincial Psychiatric Hospital (PPH) and the Royal Ottawa Hospital to a central corporate database. These hospitals were using a DOS-based case management system (Quartex) that was non-relational and not directly accessible by PPH administrators and forensic program managers (only staff from hospital clinical records departments and one corporate staff had direct access to this system). The corporate database lacked data integrity. It was vulnerable to certain source errors, including reporting errors and inconsistencies. Reporting errors occurred when one or more psychiatric hospitals failed to report information or reported information incorrectly. Reporting inconsistencies occurred when two or more hospitals interpreted the same information item differently. These kinds of errors were noted in several hospitals.

Timely access to accurate and reliable data is fundamental for the management of the provincial forensic mental health system

Feedback to hospitals and forensic programs was not timely. The only report ever generated was based on the average of three point-in-time intervals on 1994 data. The report was finally distributed September 1995. Needless to say, no meaningful program planning could be based on information (annual averages) that was almost a year out-of-date by the time it was reported. Consequently, hospitals stopped downloading this information to the central database and started to develop their own unique databases to meet their immediate needs. This resulted in data sets that are neither common across hospitals and forensic programs which makes it impossible to conduct any meaningful analyses nor is it possible to "roll up" the data at a provincial level. There has been no reporting of data for forensic mental health services for nearly a decade.

The lack of forensic data has made it very difficult to conduct timely and meaningful statistical analyses that could have significantly enhanced administrators' and program directors' ability to manage their forensic programs responsibly. The lack of information creates challenges locally / regionally with respect to the responsible fiscal, clinical and administrative management of these forensic programs and clients. Similarly, it is extremely difficult to effectively manage the forensic system provincially to ensure that all forensic programs are implemented based on evidence-based best practices, to monitor and review any deviations fiscally, clinically and administratively across programs and to ensure that the forensic system in Ontario is well-coordinated to meet the needs of all forensic clients. In addition, lack of adequate data has also hampered meaningful evaluative and epidemiological forensic research in the Province.

Lack of forensic data has compromised administrators' and program directors' ability to manage their forensic programs responsibly

Forensic programs function within broader mental health and broader inter-ministerial systems

It is important to remember that forensic programs function within the broader mental health system. The information needs of those who manage forensic programs undoubtedly will overlap with those of non-forensic mental health programs. In addition, the information needs of the forensic system can best be met based on a more comprehensive inter-ministerial Management Information System (MIS), including Ministry of Health and Long-Term Care, Ministry of Public Safety and Security, Ministry of the Attorney General and Ministry of Community, Family and Children's Services.

In order to meet the ongoing need for timely and accurate information to manage the forensic mental health system in Ontario efficiently and effectively, it is proposed that a dynamic, relational MIS be developed. A central registry of forensic client records should be established to reduce overall system costs, enhance the Ontario Review Board process and facilitate best practices research.

The forensic management information system:

- must be user friendly;
- must extract information from other databases based on a data conversion utility developed for each legacy technology;
- must provide real time data access by those in need of this information;
- must be able to accommodate the information needs of the 9 Regional Forensic Programs (some with multiple sites) and the Provincial Forensic Hospital;
- must accommodate the need to collect information from all forensic programs across Ontario in the most efficient manner;
- must be Internet browser-based to allow easy retrieval and analysis of information and makes the system both easy to manage and highly user friendly;
- must be a highly secure, centralized database system with:
  - firewalls;
  - capability of blocking all necessary ports;
  - capability of monitoring all user access; and
  - capability of implementing authentication and encryption technology;
- must have potential for future applications;
- must allow for timely reports to be developed and deployed quickly;
- must have the capability of creating both local and standardized reports that will be disseminated on an

A comprehensive Management Information System and central registry are required to manage the forensic mental health system effectively and efficiently established schedule as well as creating unique reports to address specific, idiosyncratic queries;

- must have the capability to integrate results of specialized clinical assessment tools;
- must be open-ended to allow for the inclusion of additional standardized assessment tools; and
- must have the capacity to eventually merge with a broad mental health service system MIS.

Consideration should be given to adapting the Drug and Alcohol Treatment Information System (DATIS) to meet the immediate forensic mental health information needs

To ensure both expediency and cost-effectiveness, consideration should be given to adapting an existing database that meets all criteria, such as the Drug and Alcohol Treatment Information System (DATIS) which has already been developed with funding support from the Ministry of Health and Long-Term Care and is operational. In addition to this system having the further advantage that it is used by community agencies, it also has interface capability to incorporate Residential Assessment Instrument – Mental Health (RAI-MH) data as well as with other Ministries' MISs.

RECOMMENDATION 2.4

It is recommended that, in order to meet the immediate information needs to effectively manage the forensic mental health system in Ontario, the Minister of Health and Long-Term Care support the development and implementation of a Management Information System (MIS) specific to forensic services. This MIS may serve as the prototype for a MIS that would incorporate the broader mental health system. In addition, the inter-ministerial information required for a comprehensive MIS should be amalgamated with the broader mental health MIS. Therefore, three sub-recommendations are proposed.

Recommendation 2.4.1

It is recommended that the Minister of Health and Long-Term Care support the development of a stand-alone Forensic Management Information System (MIS) to meet the immediate regional and provincial need for useful, accurate and timely information to ensure the forensic mental health system in Ontario is well coordinated and is managed in a responsible manner fiscally, clinically and administratively.

Recommendation 2.4.2

It is recommended that the Minister of Health and Long-Term Care support the interface of the Forensic Management Information System (MIS) with the planned broader Mental Health MIS to meet the regional and provincial need for useful, accurate and timely information on all forensic clients as they are integrated in non-forensic mental health programs as per Ministry policy.

Recommendation 2.4.3

It is recommended that the Minister of Health and Long-Term Care support the interface of the planned broader, comprehensive Mental Health Management Information System (MIS) with other planned Ministries' (Ministry of the Attorney General, Ministry of Public Safety and Security and Ministry of Community, Family and Children's Services) MISs to meet the regional and provincial need for useful, accurate and timely information on all forensic clients whose complex needs involve several ministries.

3. CONCEPTS AND DEFINITIONS

3.1. DEFINITION OF A FORENSIC CLIENT

Background

There is confusion about the population to be served by the forensic mental health system.

Mentally disordered persons, in conflict with the law, are sometimes channeled into the forensic system without a proper determination of their clinical (and other) needs, or without a proper review of whether those needs can be met in a health care setting. At other times, these individuals are introduced to the system without proper regard for the different legal regimes that may govern them.

The population appropriately accessing forensic beds includes persons sent for assessment, or found unfit to stand trial, or found not criminally responsible for an offence, in accordance with Part XX.1 of the *Criminal Code (Canada)* (Watt & Fuerst, 2002).

The ability to plan and provide services for mentally disordered offenders under Part XX.1 of the *Criminal Code (Canada)* (Watt & Fuerst, 2002) is adversely affected by competing demands for the admission of other mentally disordered individuals in conflict with the law.

A common definition of "forensic client" is required to facilitate service delivery and planning by all stakeholders

The population in forensic beds may, in exceptional circumstances, include:

- inmates transferred from correctional facilities for observation, care and treatment under provincial mental health legislation;
- convicted persons who have been ordered to reside in a hospital;
- civilly committed persons who are too violent or dangerous to be managed in other hospitals;

- developmentally disabled persons who do not have a placement in a facility or residential setting for the developmentally disabled; and

- a small number of young offenders who do not have a placement in a facility designated for the custody, assessment and treatment of young offenders under Part XX.1 of the *Criminal Code (Canada)* (Watt & Fuerst, 2002).

The Minister of Health and Long-Term Care has designated nine hospitals (11 sites) throughout Ontario for the custody, treatment or assessment of an accused in respect of whom an assessment order, or a disposition, or a placement decision is made. As of December 2002, a total of 568 forensic beds were operational at the following sites:

- Centre for Addiction and Mental Health
- Lakehead Psychiatric Hospital
- Mental Health Centre Penetanguishene – Oak Ridge Division
- Mental Health Centre Penetanguishene – Regional Division
- North Bay Psychiatric Hospital
- Providence Continuing Care Centre
- Regional Mental Health Care, St. Thomas, St. Joseph's Healthcare London
- St. Joseph's Healthcare System, Centre for Mountain Health Services Site
- Royal Ottawa Hospital, A Division of the Royal Ottawa Healthcare Group – Brockville Site
- Royal Ottawa Hospital, A Division of the Royal Ottawa Healthcare Group – Ottawa Site
- Whitby Mental Health Centre

Forensic clients are served by a variety of programs and services throughout the Province

Mental health programs and services for forensic clients are also provided on an outpatient basis as well as in the community through a number of service models, including Assertive Community Treatment Teams (ACTTs) and case management.

Endorsement of this recommendation will ensure that a consistent, clear definition of "forensic client" is used and understood by all stakeholders and used for planning and service delivery purposes by hospitals, community agencies and within and across Ministries.

RECOMMENDATION 3.1

It is recommended that the Ministry of Health and Long-Term Care adopt the definition of "forensic client" as a person who suffers from a major mental disorder, is in conflict with the law and is being dealt with by the courts or the Ontario Review Board under Part XX.1 - Mental Disorder of the Criminal Code (Canada).

3.2. WHEN A CLIENT CEASES TO BE A FORENSIC CLIENT

Background

The Province's policy direction in respect of mental health services contemplates that all such services will be available for forensic clients, where the client's status under the criminal justice system and his or her clinical needs permit.

The Province's policy direction also contemplates that mental health services will be available, where indicated, for persons who previously have been in conflict with the law.

Confusion about when a client ceases to be a forensic client has planning and service delivery implications

There is confusion about when a client's involvement with the criminal justice system ceases to be relevant for the purpose of providing mental health services in hospital or in the community.

Endorsement of this recommendation will ensure that there is a consistent understanding of when a person ceases to be a forensic client and that this understanding is used for planning and service delivery purposes by hospitals, community agencies and within and across Ministries.

RECOMMENDATION 3.2

It is recommended that the Ministry of Health and Long-Term Care adopt the definition as to when a "forensic client" ceases to be "forensic" when the individual is no longer subject to proceedings pursuant to Part XX.1 - Mental Disorder of the Criminal Code (Canada).

3.3. DEFINITION OF DESIGNATED FORENSIC BEDS

Background

The current definition of a forensic bed is one found in a secure forensic unit in a Regional Forensic Program or in the Provincial Forensic Hospital. This definition fails to recognize that some beds in secure forensic units are used by non-forensic clients and does not recognize the need for some forensic clients to be integrated into general mental health programmes.

A consistent and clear definition of forensic bed is required in order to collect meaningful data on the current use of forensic beds, to plan the future need for beds and to develop funding formulas. The expert panel agreed that no such consistent definition exists and that as a result, the information gathered on the number and utilization of beds was problematic.

A consistent and clear definition is required to collect meaningful data on bed usage and to develop funding formulas

In order to implement the integration policy articulated in *Making It Happen* (Ontario Ministry of Health, 1999), the definition of forensic bed must include not only those beds occupied by a forensic client but also a bed 'designated' as such by government policy. These would include 'protected / integrated' beds integrated within general mental health programmes.

Endorsement of this recommendation will ensure that a consistent and clear definition of forensic beds is applied in placing clients, compiling data, planning future needs and developing funding formulas for forensic mental health services.

RECOMMENDATION 3.3

It is recommended that the Ministry of Health and Long-Term Care adopt the definition of a "designated forensic bed" as a bed so defined and classified by Ministry of Health and Long-Term Care policy.

3.4. DEFINITION OF PROTECTED / INTEGRATED FORENSIC BEDS

Background

There are a number of non-designated beds within a hospital setting that are occupied by forensic clients. These clients do not require the level of security offered by the designated beds but are still in need of institutional care. These beds need to be counted as part of the bed ratio formula under the heading of protected / integrated. The Panel strongly supports the integration of forensic clients into non-forensic hospital programs as much as possible.

Protected / integrated beds need to be counted as part of the bed ratio formula

RECOMMENDATION 3.4

It is recommended that the Ministry of Health and Long-Term Care adopt the definition of a "protected / integrated forensic bed" as a bed outside of the Ministry designated forensic units / bed count that are occupied by forensic clients.

3.5. STANDARDIZED RISK ASSESSMENT

Background

A uniform standard for the assessment of risk for violent and / or sexual re-offending requires that the following 5 domains be addressed:

1. *Bio / psycho / social History*

   A comprehensive history based on information from family members, friends, schools, agencies and institutions. The bio / psycho / social history should include, but not be limited to, the following issues:

   - any biological and socio-cultural disposing and precipitating factors that resulted in the offense;
   - a history of physical or sexual assault or attempted assault;
   - a history of alcohol and / or drug abuse; and
   - a psychiatric history to determine evidence of psychotic disorders where the client's delusional convictions, not external reality, determined behaviour.

A uniform standard for the assessment of risk for violent and/or sexual re-offending is required

2. *Assessment of Clinical (Dynamic) Risk*

   The clinician would identify, on a case by case basis, clinical (dynamic) indicators presumptively related to increased dangerousness. These might include clinical features present at the time of previous violent offending, such as presence of specific delusions, high blood alcohol or drug levels, loss of community support network, uncontrolled anger and frustration, and a lack of treatment compliance. This assessment of clinical (dynamic) risk may use formatted or standardized protocols and / or hypothetical re-offence scenarios.

3. *Standardized assessment of anti-sociality / criminality*

   Individuals who have antisocial personality disorders / traits or who are labelled as psychopaths, have very high rates of offending / re-offending and significant criminal versatility. Antisociality or psychopathy may coexist with other mental disorders. No risk assessment regarding violent and / or sexual offending is complete without consideration of this factor.

4. *Actuarial Assessment of Risk*

   Actuarial assessment methods rely on large amounts of historical information linking certain historical events or attributes (e.g., previous arrests for impaired driving) with certain future outcomes (e.g., high accident rate). In forensic psychiatry, actuarial instruments have been developed which estimate the likelihood that an individual who has a particular history will re-offend within a defined period of time. A number of actuarial instruments for use with violent offenders and sex offenders have been made available in recent years.

Standardization is required for consistency throughout the Province

5 content domains need to be addressed

5. *The Individual's Canadian Police Information Centre (CPIC) Record*

   The history of previous offending behaviour is of direct relevance to the assessment and management of current risk. The CPIC record will be provided to the hospital by Ontario Information Service, Suspension Control Centre (Ministry of Health and Long-Term Care to negotiate centralized process and partnership for information sharing). The CPIC record will be reviewed, summarized and included in the risk assessment

Overall, the assessment and management of risk for violent and / or sexual re-offending is a core function in forensic psychiatry. Adherence to a uniform 'best practice' for risk assessment across the Province will maximize public safety and client quality of life, while minimizing liability exposure for clinicians and the Ministry.

Risk should be understood to be a continuum (low, medium, high) rather than a dichotomy (risk, no risk). Risk varies over time and circumstance. Clinicians assess risk; they do not make predictions. Risk management and prevention of violent re-offence can only be as good as the ongoing assessment.

Every forensic client should have a current assessment of risk for violent and/or sexual re-offending

All persons subject to Dispositions of the Ontario Review Board should have current assessments on file that are constructed according to an agreed protocol. The protocol must include consideration of historical and clinical elements, as well as contextual ones (e.g., access to potential victims or weapons, community supports). Risk assessment results and risk management plans should be communicated to the Ontario Review Board according to an agreed format within the Administrator's Report to the Ontario Review Board that is presented at all hearings.

Endorsement of this recommendation will ensure that, for every forensic client in Ontario, there is a current assessment of risk for violent and / or sexual re-offending that is valid, defensible and of practical utility in the management of the danger posed by the client during the community reintegration phase of his / her rehabilitation.

RECOMMENDATION 3.5

It is recommended that the Ministry of Health and Long-Term Care endorse a uniform standard for the assessment of risk for violent and / or sexual re-offending, that is comprised of the following 5 domains:

1. ***Bio / psycho / social History***
2. ***Assessment of Clinical (Dynamic) Risk***
3. ***Standardized assessment of anti-sociality / criminality***
4. ***Actuarial Assessment of Risk***
5. ***The Individual's Canadian Police Information Centre (CPIC) Record.***

3.5.1 RISK MANAGEMENT

Background

The Mental Disorder part of the *Criminal Code (Canada)* (Watt & Fuerst, 2002) requires that forensic clients must always be managed in the least restrictive and onerous manner consistent with public safety. This informs not only the custodial circumstance (i.e., maximum, medium, minimum) but also the supervision to be provided during the community reintegration phase of the client's rehabilitation.

Forensic clients represent a significant threat to the safety of the public or else they are discharged absolutely from their Ontario Review Board Disposition. Although some forensic clients have relatively minor criminal pasts, others have criminal histories that include extreme violence and / or sexual violence. Owing to the care and support provided by the mental health system in Ontario, the re-offence rate within the forensic population is relatively low, however, re-offences have occurred, and some have been major.

Risk management plans must be carefully constructed to ensure public safety

Forensic clinicians are charged with the responsibility of designing and implementing risk management strategies that will keep the public safe during the community reintegration phase of a client's rehabilitation. Risk management plans must be carefully constructed following careful consideration of all relevant information. That information should include:

- complete offence history including circumstances, weapons, victim characteristics and injuries, and social and intrapsychic contexts;
- complete mental health history including previous admissions, diagnoses, treatments, complications and incidents; and
- complete risk assessment according to a provincial 'best practice' standard.

The risk management plan should be comprised of the following domains:

- presumed clinical or dynamic risk factors, and specific management interventions to respond to ominous developments regarding each;
- specific supervisory practices in-hospital, on hospital grounds, in community;
- identification of likely victim / pool;
- identification of likely offences;
- identification of likely location / context of likely offences;
- identification of likely behaviour (including movement / location) following likely offences;
- identification of likely weapons, if any; and
- identification of specific mechanics and information to be provided to appropriate authorities regarding the risk management plan, regarding changes in the plan, regarding failure to comply with plan, and regarding re-offence.

Comprehensive risk management plans will reduce forensic client re-offence

Endorsement of this recommendation would reduce forensic client re-offence by ensuring uniform compliance with a "best practices" model of risk management planning, implementation and documentation for all clients who have any access to potential victims in the general population.

Recommendation 3.5.1

It is recommended that the Ministry of Health and Long-Term Care endorse uniform protocols for risk management plans regarding forensic clients engaged in the community reintegration phase of their rehabilitation.

4 SYSTEM CAPACITY AND INTEGRATION

4.1. FORENSIC BED RATIO POLICY

Background

In many regions of Ontario, demand for forensic beds and / or utilization exceeds the minimum bed ratio at the present time. Community service development has not reduced demand significantly to date. It would be wise to regard the Ministry's forensic bed ratio policy as setting minimum requirements until such time as community service development results in lower demand for beds.

This bed demand in excess of availability has meant that, on some occasions, forensic clients have been held in custody for unacceptably long periods of time awaiting the availability of a forensic bed.

The Ministry's bed ratio was determined in 1997 (Ontario Ministry of Health, 1997b). It is unclear whether the same forensic bed-to-population ratio is appropriate for all regions of Ontario. Other factors, such as community development, can influence demand for forensic beds. Admission to forensic beds is under the influence of an independent judiciary and the Ontario Review Board, and thus not under the direct control of the Ministry of health and Long-Term Care. To ensure the most appropriate use of costly specialized services, there should be a process to regularly review forensic bed needs on a region by region basis. Please refer to the Management Information System recommendation as a necessary prerequisite in support of this recommendation.

Regular review of forensic bed needs by region is necessary to ensue that bed allocations meet service needs

The following table illustrates the Ministry's original forensic plan for the number of forensic bed ratios per 100,000 adults in the Province in 1998, the current forensic bed ratios per 100,000 adults based on a snapshot in 2002, and the Panel's recommended bed ratios per 100,000 adults for designated long-stay / maximum secure beds, designated regional forensic beds and protected / integrated beds per 100,000 adults.

ONTARIO FORENSIC BED RATIO PER 100,000 ADULTS

	MOHLTC Forensic Plan (1998)*	Current Forensic Bed Ratio (2002)	MOHLTC Planned Forensic Bed Ratio	Expert Panel Recommended Forensic Bed Ratio
Designated Long-Stay / Maximum Secure	1.4	1.4	1.4	1.4
Designated Regional Forensic Beds	3.5	4.3	5.2	5.2
Protected / Integrated Beds	TBD	1.6	3.0	3.0
Total	4.9	7.3	9.6	9.6

* Based on a population of 9.89M adult population (16 years of age and older in 1998)

RECOMMENDATION 4.1

It is recommended that the Ministry of Health and Long-Term Care's forensic bed ratio policy be reinforced as a minimum ratio, with a focus on significantly enhancing community services, such as diversion, housing and intensive case management.

It is further recommended that the Ministry's forensic bed ratio be reviewed to determine whether the existing ratio of forensic beds per 100,000 adult population accurately reflects current need. Because population rates fluctuate, the issue of appropriate number of forensic beds will need to be reviewed every two years.

It is further recommended that the Ministry accepts the Panel's recommended ratios of 1.4 beds per 100,000 adults for designated long stay / maximum secure beds, 5.2 beds per 100,000 adults for designated regional secure beds and 3.0 for protected / integrated beds per 100,000 adult population.

4.2. ASSERTIVE COMMUNITY TREATMENT TEAMS (ACTTs)

Background

In 1999, the MOHLTC implemented a policy facilitating the development of Assertive Community Treatment Teams (ACTTs) in Ontario. At present, there are 61 full or partial ACTTs in the Province. ACTTs have demonstrated effectiveness in providing community support for the seriously mentally ill. Nevertheless, some criticism has been leveled at ACTTs for lack of timeliness in accepting referrals and in achieving the numbers of clients targeted.

The forensic population must be served appropriately by all Assertive Community Treatment Teams

It is essential, therefore, that any evaluation of ACTTs across Ontario assess to what degree ACTTs are serving the forensic population and what successes and difficulties have been experienced.

The fundamental principle that must be endorsed is that the forensic population must be served by ACTTs with appropriate provision for training and human resource expertise. Access to forensic expertise for consultation purposes should be available to all ACTTs.

RECOMMENDATION 4.2

It is recommended that the Ministry of Health and Long-Term Care enforce the existing standards for the provision of forensic service by Assertive Community Treatment Teams, with a focus on implementation of the admission criterion for clients who are a high risk or have a recent history of criminal justice involvement (Recommended Standards for Assertive Community Treatment Teams, Ontario Ministry of Health, 1998b).

4.3. CASE MANAGEMENT SERVICES

Background

Case management is a service that encompasses a continuum of flexible, comprehensive interventions to coordinate a fragmented system for persons with disabilities. The relationship between case manager and client is the core of case management.

Assertive outreach case management, as a model of community service delivery, assists individuals to negotiate a fragmented system. The model needs to be accessible and comprehensive to meet all of the clients' needs. Services need to be client-directed and have full client involvement. The medical aspects of care should not be the sole focus of case management services. Some clients do not require medication and others make competent decisions to pursue other modalities of treatment. The Psychosocial Rehabilitation model is less medically focussed, uses more of a community-centred approach, and addresses the needs of many clients.

Case management services provide an alternative model of community service delivery offering a continuum of flexible and comprehensive interventions

Individuals with mental health issues who find themselves in conflict with the law often have no housing and no community supports. With the availability of outreach case management programs, involvement with the criminal justice system should decrease and thereby reduce the demand for forensic beds and access to the correctional facilities. With these supports available, mental health court workers will have somewhere to refer individuals to assist with successful mental health diversion disposition. Some unfit individuals with minor offences could be released to the community with intensive follow-up by a case manager.

RECOMMENDATION 4.3

It is recommended that the Ministry of Health and Long-Term Care make available a variety of case management services to the forensic population. These models of assertive case management services should be flexible in referral criteria and should provide a range of approaches, from an intensive case management model to an after care model.

4.4. MENTAL HEALTH COURT SUPPORT SERVICES

Background

Mental Health Court Support Services (MHCSS) began in September 1995 with a pilot project providing an on-site mental health worker at Old City Hall. Ottawa started a similar program in August 1995. Today, there are now MHCSSs in most of Ontario's major cities and many smaller jurisdictions.

The program has been shown to be an invaluable option to assist individuals with a mental health issue who are in conflict with the law. The program focuses on assisting individuals with plans for community support and treatment to increase the likelihood that the Crown attorney will agree to mental health diversion or a sentence of probation over jail time. This approach is focused on stability of the individual in the community by ensuring that community supports are in place and preventing the individual from re-offending.

Although the program has been considered very successful, there have been many issues identified that need to be addressed. Over the years, there has been little consistency of practice throughout the Province. The programs are operated by numerous community mental health agencies with different mission statements, policies and procedures. Some agencies are very clear that they will only deal with clients that have low-risk offences. Other agencies are willing to assist with any situation.

Mental health court support services is an invaluable option to assist individuals with a mental issue who are in conflict with the law

Consistency in practice by Court Support Workers is important

The role of the Mental Health Court Worker (MHCW) has been inconsistent. The court often feels that the MHCW is there to support the court. This assumption is played out in many different scenarios, such as being placed on bail and probation orders, being asked to testify, expected to provide "expert" input on fitness and bail releases. The role of the MHCW is to offer support and services to the client of the program.

Many of these issues were addressed in *A Review of Mental Health Services in the Toronto Courts* (Macfarlane, Blackburn, Bullock, Doob, Haber, Pyke & Robins, 2002). The recommendations of this review should be supported.

It is also noted that these programs are severely under-resourced in terms of the number of MHCWs, case managers and administrative support.

RECOMMENDATION 4.4

It is recommended that the Ministry of Health and Long-Term Care address mental health court support services with respect to increasing resources and developing guidelines in terms of standard of practice, accountability and evaluation.

4.5. FORENSIC CLIENT INTEGRATION

Background

A number of forensic clients do not require the specialized expertise and resources of a Regional Forensic Program. Some forensic clients, in accordance with Ministry of Health and Long-Term Care policy, should be integrated into general mental health inpatient and outpatient programs and into the broader mental health service system to best address the needs of the client. The Ministry of Health and Long-Term Care's approved "Protected/Integrated Beds" program, which is an administrative device to achieve greater integration of lower risk forensic clients into broader mental health programs, must be implemented by all health care facilities that have Regional Forensic Programs. This will serve to decrease the stigma directed towards forensic patients and ensure the most efficient and effective use of resources by clustering patients with similar clinical needs. Scarce forensic mental health professionals will use their highly specialized expertise for those patients who have a history of violence, who present a significant risk for violence or who require specialized assessment and / or care.

Forensic clients need to be integrated into general mental health inpatient and outpatient programs and into the broader mental health service system

Integration reduces stigma

Regional Forensic Programs, from which lower risk clients are referred, should not continue to bear the responsibility for ongoing supervision and legal / administrative matters. This responsibility will fall more appropriately to the Person-in-Charge and could be discharged by a person assigned to that task centrally within the facility. Transfers to non-forensic services should only be contemplated for persons:

- whose risk of violent offending, as assessed by a protocol acceptable to the Ministry of Health and Long-Term care, is considered as being low; or
- who are subject to conditional discharge orders.

Clients transferred to non-forensic programs will become the responsibility of that program. Requests for return to the Regional Forensic Program will be managed in the customary referral and consultation manner except where a revised Disposition requires placement in a Regional Forensic Program.

Recommendation 4.5

It is recommended that the Ministry of Health and Long-Term Care policy directing the principle of forensic client integration in non-forensic services (hospital and community-based) be enforced. Forensic clients at a lower security risk should be accommodated in "protected / integrated beds" located in other areas outside of a Regional Forensic Programs provided that forensic expertise is available on a consultative basis, that staff have appropriate information about the care and management of forensic clients and proper financial arrangements could be negotiated with the government. The Ministry should also firmly enforce the existing policy that a forensic designation is not grounds to refuse admission to a required service.

4.6. BALANCING FORENSIC AND NON-FORENSIC RESOURCES

Background

Current Ministry of Health and Long-Term Care policy does not address the potential impact of an increasing demand for forensic mental health services on existing non-forensic services. Nor does existing mental health policy anticipate the necessity to ensure that mental health beds are used as flexibly, effectively and efficiently as possible. Mental health facilities have a dual responsibility to provide inpatient and outpatient services to their communities in accordance with the Ontario Mental Health Act and the mentally disordered offender provisions of the *Criminal Code (Canada)* (Watt & Fuerst, 2002). Consistent with mental health reform principles, both mandates must have equal priority.

As a result of the work of the Health Services Restructuring Commission (Ontario Ministry of Health, 1997b), a bed ratio of 35 adult beds/100,000 adults in 2003 was set as a target for mental health beds in Ontario's mental health facilities. This ratio represents a combination of acute care and long stay / specialized adult mental health beds. The Forensic Mental Health Services Expert Advisory Panel has recommended a forensic bed ratio of 9.6 adult forensic beds/100,000 adults.

Increasing demand for forensic mental health services has a direct impact on existing non-forensic services

A clearly defined policy framework is required to prevent the erosion of non-forensic services

As noted in Recommendation 4.5, achieving effective integration of forensic clients into non-forensic services at the inpatient, outpatient and community level must be strongly supported by Ministry of Health and Long-Term Care policy and by mental health service providers. This can best be achieved by the development of a Ministry of Health and Long-Term Care policy that requires the effective integration of forensic clients into non-forensic programs and an approach that eliminates barriers to this occurring.

Similarly, the Ministry of Health and Long-Term Care must recognize that a necessary precipitant to effective forensic client integration is the development of a policy that recognizes the dual mandate of mental health services, that defines the capacity and resources needed to meet the dual mandate and that fosters and ensures the flexible, effective and efficient use of mental health adult beds. Without a clearly defined policy framework of this nature, there is a very real risk that, with the continuing demand for forensic services, important non-forensic services will be compromised or be eliminated.

Recommendation 4.6

It is recommended that the Ministry of Health and Long-Term Care formulate a policy that addresses the necessity for achieving a balance between forensic and non-forensic inpatient and outpatient services provided by mental health facilities.

4.7. RESPONSIBILITY OF THE FORENSIC SYSTEM TO SUPPORT THE MENTAL HEALTH SYSTEM

Background

The overall mental health treatment system will provide care to increased numbers of forensic clients. It will be essential to ensure the service providers have access to forensic expertise, consultation, and education to ensure the forensic aspects of their care are properly addressed. This should also increase the comfort of non-forensic staff caring for forensic clients.

Service providers must have access to forensic expertise

RECOMMENDATION 4.7

It is recommended that the Ministry of Health and Long-Term Care endorse the concept that the forensic system, as an important part of the overall mental health system (including community programs), has a responsibility to make itself available to other parts of the mental health system, especially for consultations and educational activities.

4.8. FINANCIAL RESOURCES FOR FORENSIC PROGRAMS AND SERVICES

Background

There is evidence that existing forensic programs have not been funded equitably. This has resulted in variations in resources available to provide care to clients. It also results in variation in the degree of security, treatment and rehabilitation services provided for similar clients in different facilities.

Forensic programs must be funded equitably

RECOMMENDATION 4.8

It is recommended that the Ministry of Health and Long-Term Care ensure that an equitable funding formula be applied to each Regional Forensic Program.

4.9. PROVINCIAL FORENSIC HOSPITAL

Background

Many mentally disordered offenders who have committed a violent crime, and are at high risk of re-offending because of their mental illness, require considerable time in a secure hospital setting. These clients are not suitable candidates for significant community access within two years. Consistent with Mental Health Reform initiatives and Ministry policy articulated in *Making It Happen* (Ontario Ministry of Health, 1999), this high security / long-stay service will be provided at a single provincial site designated as the Provincial Forensic Hospital. The Provincial Forensic Hospital is a facility designed and resourced so as to provide for both privacy and significant freedom of movement within a secure perimeter for persons who are not permitted significant community access and who require interventions for the treatment and management of disturbed behaviour. Services provided by the Provincial Forensic Hospital will emphasize quality of life issues by ensuring access to a variety of diversional activities and by providing for access to a broad range of therapeutic, educational and vocational activities within a secure perimeter. Clinical program elements will emphasize

Replacement of the outdated facilities at the Mental Health Centre Penetanguishene, Oak Ridge Division, is essential in meeting the needs of the high security / long-stay forensic mental health population acquisition of insight into illness and risk factors, coping with anger and other high risk internal states, abnormal sexual preferences and other areas that require concentrated attention. The rehabilitation phase will occur prior to the point when community access is considered possible without subjecting the public to unacceptable risk to their safety. Program development will take place with the collaboration of the provincial Academic Health Sciences programs and coordinated with other Regional Forensic Programs.

The Provincial Forensic Hospital also serves a small number of clients within the Ontario forensic mental health system who represent uniquely difficult challenges for institutional care. These are clients who engage in behaviours such as repetitive institutional violence, represent very high risks for escape, engage in sexual predation within the institutional setting, engage in fire setting behaviour or are seriously regressed.

The Provincial Forensic Hospital has very high levels of both static and dynamic security and staff are specifically trained and highly experienced with this client group.

RECOMMENDATION 4.9

For purposes of economies of scale and critical mass of staff and resources, the Panel reaffirms the Ministry of Health and Long-Term Care's policy to have one Provincial Forensic Hospital in the Province and recommends the replacement of the outdated facilities in existence at the Mental Health Centre Penetanguishene, Oak Ridge Division, as soon as possible.

4.10. REPATRIATION OF FORENSIC CLIENTS WITHIN THE MENTAL HEALTH SYSTEM

Background

Difficulty has been experienced in transferring clients back to the regional facilities from which they originated when they no longer need the level of security and / or treatment provided by the Provincial Forensic Hospital. To ensure that clients are held in the least restrictive environment compatible with public safety, they must be repatriated in a timely fashion. This ensures the most efficient use of costly specialized service and ensures beds are available in the Provincial Forensic Hospital when needed.

Forensic clients must be repatriated in a timely fashion

RECOMMENDATION 4.10

It is recommended that civilly committed offenders and Ontario Review Board (ORB) clients who are transferred to the Provincial Forensic Hospital from regional facilities due to management / treatment issues be repatriated in accordance with an agreed provincial protocol.

4.11. IMPACT OF GENERAL PSYCHIATRIC BED AVAILABILITY ON THE FORENSIC SYSTEM

Background

The Ministry of Health and Long-Term Care should be made aware that restrictions of access to general mental health beds may have an impact on access to forensic beds. The proposed bed closures as per the Health Services Restructuring Commission (Ontario Ministry of Health, 1997b) recommendations will compromise the health care facilities' ability to implement the Ministry's forensic mental health integration policy.

Proposed bed closures will compromise the implementation of the Ministry's forensic client integration policy

To successfully implement the Ministry's integration policy, it is imperative that general mental health beds be maintained in the system to meet the needs of increasing numbers of forensic clients in Regional Forensic Programs who could transfer from forensic beds to general mental health beds. Many clients are unable to be integrated as a result of insufficient general mental health beds in the system.

In addition, clients who previously spent long periods in longer-term treatment beds in psychiatric hospitals will now be living in the community with intensive supports. Behaviour that did not give rise to criminal charges in hospitalized clients may result in charges for those in the community. These same clients mostly suffer from severe, chronic, complex mental health problems for which unpredictable, acute exacerbations are the norm. Hospitalization is often required to properly treat these exacerbations, so there will need to be a system in place to allow timely admissions to acute mental health facilities when required. In the past, these acute exacerbations were generally treated in long term beds. These clients will create additional new pressures. As a result, they may not be available to integrate forensic clients into the general mental health system.

RECOMMENDATION 4.11

It is recommended that the Ministry of Health and Long-Term Care make no further reduction in the availability of acute or long-term general mental health beds until there is a documented decrease in demand for those beds.

4.12. *RANGE OF FORENSIC SERVICES IN ONTARIO* DOCUMENT

Background

The purpose of the *Range of Forensic Services in Ontario* document (Ontario Ministry of Health and Long-Term Care, 2002; refer to Appendix B) is to provide recommendations prepared by the provincial forensic directors to the Minister of Health and Long-Term Care. These recommendations establish common definitions and identify the range of forensic services in Ontario required to provide the quality of care and supports that leads to safe reintegration of mentally disordered accused and offenders into the least intrusive environment.

The *Range of Forensic Services in Ontario* (2002) outlines a comprehensive forensic mental health system for the Province

The basic structure of a comprehensive forensic mental health service system for Ontario is outlined. This framework, which is consistent with government policy, must incorporate several facets of an integrated system that impact directly and indirectly on the efficient and effective delivery of forensic mental health services throughout Ontario. As such, violence prevention and court diversion services are considered of equal importance to assessment, inpatient, outpatient, consultation and specialty services. The provincial coordination of forensic services is also integral to the development of a comprehensive forensic mental health service system for Ontario.

Not all services described in this document exist at this time. A series of recommendations are provided in order to develop and implement a comprehensive forensic mental health service system for Ontario that will meet the needs of the mentally disordered accused and offenders in the manner described.

RECOMMENDATION 4.12

> ***It is recommended that the Ministry of Health and Long-Term Care adopt as policy the document entitled Range of Forensic Services in Ontario (Ontario Ministry of Health and Long-Term Care, 2002) and the associated recommendations developed by the Forensic Directors Group.***

5. INTER-MINISTERIAL ISSUES

5.1. AFFORDABLE SUPPORTIVE HOUSING FOR THE SERIOUSLY MENTALLY ILL WHO ARE IN CONFLICT WITH THE LAW

Background

A lack of safe, affordable, appropriate supportive housing available to mentally disordered offenders has been an ongoing issue that has increased the need for forensic services in Ontario. For example, 50% of the individuals seen in Toronto's Mental Health Court have no fixed address. In addition, a number of individuals hospitalized on a "Not Criminally

Responsible" (NCR) Disposition remain so because of a lack of supportive housing in the community. Increasing supportive housing availability for NCR clients whose assessed risk to public safety is minimal would significantly enhance the implementation of the government's policy commitment, as stated in *Making It Happen* (Ontario Ministry of Health, 1999), for community reintegration.

A wide array of housing options, depending on the individuals' needs, functioning levels and legal dispositions, must be available for successful community reintegration. The array of housing includes:

Lack of supportive housing has a direct impact on service provision to mentally disordered offenders

- **High Support** (24 hour a day staff);
- **Medium Support** (daily staff support, not overnight);
- **Low Support** (once a week staff support);
- **On Call Support** (staff available on an on-call basis); and
- **Variable Support** (support that can vary from time to time, depending on the individual's needs and preferences).

All housing options should be made available on a supportive, rent-geared-to-income basis. Private rooms, whether in a boarding house, rooming house or self-contained apartments, should be available to all individuals.

Availability of supportive housing would have several positive impacts on mentally disordered offenders

The aforementioned housing options would greatly assist with bail releases, individuals awaiting trial and sentences, and mental health diversion plans. Greater access to supportive housing in the community would result in more releases to the community, particularly for individuals who have very minor charges pending. An array of appropriate available housing options would assist in preventing individuals from entering the forensic system.

RECOMMENDATION 5.1

It is recommended that the Ministry of Health and Long-Term Care develop a range of affordable supportive accommodations to address the housing needs of seriously mentally ill individuals on dispositions, individuals with special needs who are in conflict with the law released on court order, individuals who are "fit" or "unfit" with trial pending and with no known address, individuals who are discharged from detention, and individuals who are on probation and / or court diversion.

5.2. COURT ORDERED ASSESSMENTS

Background

There is a need for a more efficient triage system as part of the legal process. There is a significant overuse of mental health services by the criminal justice system where the courts order multiple assessments, particularly for fitness to stand trial. This recommendation would lead to an increase in responsibility and accountability for these criminal cases until they come under the Ministry of Health and Long-Term Care's jurisdiction. Short-term (e.g., in custody, in court) fitness assessments are preferred. There is a need to discuss further the issue of whether assessments of risk / dangerousness or fitness to stand trial require a bed to complete the assessment (many of these assessments should be done in custody or at court).

Involvement of the courts in the mental health system may distort the aims of justice

The criminal justice system must make more appropriate use of mental health resources

There is a significant number of "Not Criminally Responsible" (NCR) assessments ordered by the courts. From a resources perspective, psychiatric assessments are very expensive and some individuals are sent for assessment by the courts when, in reality, they are really being sent for care, although treatment may, in fact, be legally impossible.

Endorsement of this recommendation will address the concern that involvement of the courts in the mental health system may distort the aims of justice. The problem is the perceived inappropriate use of mental health system resources by the justice system. The Ministry of the Attorney General needs to develop accountability mechanisms in order to determine the number of individuals in the system and costs associated with processing these individuals.

RECOMMENDATION 5.2

It is recommended that the Ministry of Health and Long-Term Care consider all court ordered assessments under Part XX.1 Criminal Code (Canada) as a direct support to the justice system and, therefore, funded by the justice system.

Following the mandate of Section 672.16, court ordered fitness assessments should be done out of hospital.

If a hospital setting is required, the order must provide for the immediate return of the client to the criminal justice system following the completion of the assessment.

Public hospitals must enhance their current role by providing services to low risk mentally disordered offenders and to seriously mentally ill persons at risk for criminal behaviour.

5.3. MANAGEMENT OF FORENSIC CLIENTS IN AN INTEGRATED INTER-MINISTERIAL SYSTEM

Background

Two keys to preventing mentally ill persons from becoming forensic clients are the prevention measures in place in the community (e.g., diversion programs) and the degree of coordination and collaboration that exists between service providers and Ministry partners. These key elements require sensitive and flexible referral processes between organizations as well as mechanisms to encourage and improve effective collaboration between professional staff and agencies in the health, social services and criminal justice sectors. Coordination by "follow-up" workers from the host / sending facilities would ensure that mentally ill persons who are in conflict with the law are linked to a service provider to enhance continuity of care and public safety while reducing victimization.

Continuity of care for mentally disordered offenders across Ministries and public safety require proper discharge planning and thorough "follow-up" by case workers

This is considered especially important in light of the development of "super jails" which will tend to centralize prison management at a time when mental health systems are decentralizing. Proper discharge planning and thorough "follow-up" by caseworkers from the correctional system will be even more essential.

RECOMMENDATION 5.3

It is recommended that the Ministry of Health and Long-Term Care, in partnership with affected Ministries, support that, when clients move from one system to another, such as from the correctional system to the mental health or social services systems and vice versa, "follow-up" case workers from the host / sending facilities liaise with them to enhance continuity of care and public safety while reducing victimization.

5.4. CROWN POLICY ON MENTAL HEALTH DIVERSION

Background

The Crown policy on mental health diversion was first introduced in 1994. The policy involved an agreement between the Ministry of Health and Long-Term Care and the Ministry of the Attorney General. The policy states that if an individual suffering from a mental illness has committed a low-risk offence, and a treatment facility was willing to accept the individual, the Crown attorney had the discretion to withdraw the charges.

Crown policy on mental health diversion requires revision

In practice, the difficulty with the implementation of this policy is that the individual would not have access to the treatment facility. The Crown would withdraw the charges with the understanding that the individual would attend at a specified treatment facility on their release. In most instances, the individual would not make it to the treatment facilities.. There was no order binding them to the court system. It many of these situations, there was no opportunity for community supports and treatment to be put in place to stabilize the individual so that they would not re-offend.

Between 1995 to date, Mental Health Court Support Services (MHCSS), sponsored by a number of community mental health agencies, provided a link between the criminal justice system and community mental health. Mental health diversion became a successful option for the individual and the criminal justice system.

The original Crown policy of mental health diversion requires revision. There have been many changes in legislation and availability of supports since 1994. These changes need to be reviewed and incorporated in a new Crown policy for mental health diversion.

RECOMMENDATION 5.4

It is recommended that Crown policy on mental health diversion be reviewed and revised in consultation with representatives of Mental Health Court Support Services, Ministry of Health and Long-Term Care, Ministry of the Attorney General, Ministry of Community, Family and Children's Services, community mental health agencies providing the service, individuals who are developmentally disabled, victims of acquired brain injury, consumer survivors and other appropriate stakeholders.

5.5. POLICE DIVERSION FOR PERSONS WITH MENTAL ILLNESS (PRE-CHARGE DIVERSION)

Background

Pre-charge diversion relies heavily on a police officer's common law discretion. Public safety in relation to the continuation of the offence is of primary concern to the officer. Anecdotally, many officers will exercise their discretion by apprehending the individual pursuant to the Mental Health Act rather than proceeding with criminal charges. Unfortunately, this results in an increased burden to the general hospital system and provides no accountability in relation to the criminal allegations.

While established community based mobile crisis intervention services may seem a viable alternative, there is no component to compel an individual to participate in them as an alternative to hospitalization / criminal charges.

The development of standardized guidelines and programmes will serve two fundamental purposes:

1. Enhance officer discretion by providing a 'third option' to the traditional practice of 'hospitalize or criminalize'. This may reduce the number of persons with mental illness incarcerated for minor offences while ensuring that their mental health needs are addressed and ensuring that the criminal allegations are addressed / documented; and
2. Ensure that police officers fulfil their duties pursuant to the Police Services Act and the Victim's Bill of Rights thus maintaining the integrity of policing in Ontario.

Development of standardized guidelines and diversion programmes will assist police officers when they come in contact with mentally disordered offenders

Methods of diversion to be explored should include but not limited to:

1. Enhanced officer training similar to the Memphis Police Department's Crisis Intervention Team;
2. Multidisciplinary teams similar to Vancouver's 'Car 87' or Hamilton's Crisis Outreach and Support Teams (COAST); and
3. Community / restorative justice models.

Implementation of any of the aforementioned initiatives (adapted to local conditions / requirements) will require a needs assessment based on a region's population, community based services and demands on the respective police service. In additional, it is imperative that appropriate community resources are in place to implement this recommendation.

RECOMMENDATION 5.5

It is recommended that the Ministry of Health and Long Term Care, in conjunction with the Ministry of the Attorney General and the Ministry for Public Safety and Security, develop provincial educational / training guidelines and programmes for police officers in relation to diverting persons with mental illness, where accused of committing minor offences, from the criminal justice system.

Provincial directives between the Schedule 1 facilities and the Local Police Services must be established and maintained.

5.6. USE OF TELECOMMUNICATIONS FOR FORENSIC ASSESSMENTS

Background

Telemedicine is an enabling technology utilized in many countries with the purpose of enhancing access to health care for persons who are geographically isolated and under-served. The American Psychiatric Association defines telepsychiatry as "the use of electronic communication and information technologies to provide or support clinical psychiatric care at a distance." This definition includes all distant communication modalities such as telephone, faxes, e-mails, still imaging, Internet and live two-way audio-visual communication systems. Strictly speaking, it is the last means of communications, live two-way audio-visual capabilities that are considered for telehealth and, possibly, for telelaw.

Technological advancements in telecommunications can enhance service provision in forensic mental health

Systems of this nature can be used and are used for consultations, assessments and diagnosis, treatment follow-up, case-conferencing, forensic and legal assessments, research and education. These technologies are not new and are used extensively in Canada and many other countries. Earlier concerns about the technical capabilities of the different systems regarding reliability and dependability of the system and quality of transmission have now been answered. Equally, concerns about confidentiality of the transmitted data, possibilities of snooping or breaking into a transmission and privacy have also been dealt with new developments in encryption capabilities. Questions on ownership and guardianship of clinical records and on the clinical and legal responsibilities that should accrue to the requesting clinician and the responding consultant have also been answered satisfactorily.

Similar systems are already in use for legal purposes. Oftentimes, it would be more expeditious and even safer not to transfer an inmate to the court. The inmate could "be present" throughout the proceedings via telelaw and answer whatever questions posed by the Judge or by counsels. A system of this type exists in Calgary and is used also by forensic psychiatrists who examine the inmate right from the court when the inmate is at the remand centre that is located far in the outskirts of the city. In a larger system, a forensic psychiatrist could also interview an inmate directly from the forensic unit without having to go to the remand centre to examine the inmate prior to court appearance or to the court to give evidence. The psychiatrist could provide testimony and answer questions directly from the forensic unit. Experience with these procedures demonstrates that, within clearly defined legal, ethical and clinical parameters, they serve the needs of justice to the satisfaction of the users and decision-makers in law. When distances and penury of personnel are an issue, telemedicine and telelaw are practical solutions.

Telecommunications in forensic mental health warrants further investigation

RECOMMENDATION 5.6

In order to expedite assessments, make better use of clinical personnel and decrease potentially unnecessary admissions to the Regional Forensic Programs and the Provincial Forensic Hospital, it is recommended that the Ministry of Health and Long-Term Care, in concert with the Ministry of the Attorney General, explore a system of telehealth / telelaw connecting both remand centres and court systems to the Regional Forensic Programs and the Provincial Forensic Hospital.

5.7. IMPACT OF PROVINCIAL CORRECTIONAL FACILITIES ON THE MENTAL HEALTH SYSTEM

Background

Approximately 20% of inmates in provincial correctional facilities suffer from a major mental disorder. Some of these individuals require services that, generally, are available only within provincial psychiatric or specialty hospitals.

The creation of large provincial "super-jails" to replace smaller local and regional jails and detention centers has resulted in a focusing of correctional system demand for provincial mental health resources onto secure forensic programs within these psychiatric or specialty hospitals. When a thousand bed correctional facility is built within the catchment area of such a hospital, a potential exists to overwhelm the available secure mental health services.

"Super-jails" create additional demands on forensic programs

There is a need to develop and implement a protocol to provide for access to provincial mental health resources by inmates of correctional facilities

An additional impact of the super-jail is in the discharge process and relinking of released sentenced inmates back to local service providers. With the closure of local and regional jails, many of the arrangements currently in place to ensure continuity of mental health care will be lost.

The Ministry of Public Safety and Security may create Schedule 1 beds within one or more of its own secure facilities. However, to the extent that large correctional facilities exist that do not have their own capacity to manage acute episodes of major mental disorder, the Ministry of Health and Long-Term Care and the Ministry of Public Safety and Security should develop and implement a protocol to provide for access to provincial mental health resources by inmates of correctional facilities.

Endorsement of this recommendation would serve to delineate the circumstances and conditions under which inmates of provincial correctional facilities will access provincial and regional mental health resources.

RECOMMENDATION 5.7

It is recommended that the Ministry of Health and Long-Term Care and the Ministry of Public Safety and Security jointly develop a provincial protocol regarding the manner in which inmates of provincial correctional facilities access provincial and regional mental health resources and how they are linked into services in their home communities at the end of their sentences.

Due to recent proposed changes in how the Ministry of Health and Long-Term Care and the Ministry of Public Safety and Security will be managing the provision of mental health services to inmates in provincial correctional facilities, a provincial protocol is required to establish the roles and responsibilities of both parties.

5.8. SPECIAL POPULATIONS

Background

The panel recommends that each Ministry provide appropriate resources to each forensic client belonging to special populations, including:

- female forensic clients;
- Aboriginal forensic clients;
- young offenders (MCFCS);
- dually diagnosed (mentally ill and developmentally disabled) (MCFCS); and
- seniors.

Appropriate inpatient facilities and support systems are required to protect vulnerable clients

It is essential that vulnerable clients, in particular those who are vulnerable to sexual predation, be provided with appropriate inpatient facilities and support systems that enable their proper protection. All Ministry of Health and Long-Term Care Regional Forensic Programs should have the capacity to provide gender segregated inpatient facilities. The capacity to sub-divide forensic units into smaller units (6-8 clients) is helpful in order to tailor clinical services and protection to the needs of clients.

Resources will need to be identified in order to assess the special needs of these groups and develop or modify facilities, programs, support systems and human resources to meet their needs. Partner Ministries should establish protocols to meet the needs of these common clients. This is in keeping with the roles and responsibilities articulated in the *Human Services and Justice Coordination Project* (Human Services and Justice Coordination Project, 1997).

RECOMMENDATION 5.8

In keeping with the roles and responsibilities articulated in the Human Services and Justice Coordination Project (1997), it is recommended that each of the partner Ministries formally acknowledge and accept their roles and responsibilities to establish and resource the necessary treatment capacity and support systems for their special target populations.

5.9. SPECIAL ROLE OF THE CROWN PROSECUTOR

Background

At present the Ministry of the Attorney General has a formal policy concerning the diversion of mentally disordered persons. The current version of this policy states in its introduction that:

> "In furtherance of the agreement reached between the Ministry of Health and the Ministry of the Attorney General, the following Crown Counsel Policy for the diversion of mentally disordered accused has been established.
>
> It is acknowledged that this diversion program is an appropriate response to mentally disordered offenders, whether adult or young person, who may find themselves in conflict with the criminal justice system primarily because of their mental disorder. With the co-operation of

> the Ministries of Health and the Attorney General it is expected that these types of offenders can obtain access to the necessary treatment and support they require to minimize their contact with the criminal justice system in the future.
>
> For the purposes of this policy, diversion is defined as a pre-trial procedure where Crown counsel uses his or her discretion on a case-by-case basis not to prosecute an accused. Instead, the accused is referred to a person, service or hospital with the intent of having the accused embark upon a treatment program to address his or her particular treatment needs.
>
> Participation in a diversion program is voluntary. In the absence of exceptional circumstances, the Crown relinquishes its right to prosecute the divertee for the offence which gave rise to the decision to divert, regardless of the outcome of the diversion."

At present, not all Crown Attorneys Offices in the Province of Ontario possess the resources to offer formal diversion programs to mentally disordered offenders.

The Ministry of the Attorney General also currently provides training that extends to some Crown prosecutors a special designation that recognizes them as specialists trained and qualified to provide expert advice and advocacy under Part XX.1 (Mentally Disordered Accused) of the *Criminal Code (Canada)* (Watt & Fuerst, 2002). These Crown prosecutors also appear as Attorney General representatives at Ontario Review Board hearings

In order for Crown prosecutors to become eligible for this specialized designation, they are expected, among other matters, to undergo a weeklong training session presented by the Ministry of the Attorney General and its educational partner, the Ontario Crown Attorneys Association.

Each and every Crown Attorneys Office requires specially trained Crown prosecutors to assist mentally disordered offenders

The Ministry of Health and Long-Term Care can assist by providing educational resources to support the Ministry of the Attorney General

In support of and to enhance the Ministry of the Attorney General's initiatives concerning mentally disordered offenders, there is a need to ensure that there are specially trained Crown prosecutors in each and every Crown Attorneys Office who are knowledgeable and skillful in dealing with the special needs of mentally disordered accused persons and offenders

The Ministry of Health and Long-Term Care should make available any of its relevant educational resources to the Ministry of the Attorney General in order to support this effort.

Support for this recommendation will provide specially trained Crown prosecutors positioned in all Crown Attorneys Offices in the Province of Ontario who possess sufficient knowledge and have the necessary skills to address the needs of this special needs population, namely, mentally disordered accused persons and offenders and provide best advice to less experienced Crown prosecutors.

RECOMMENDATION 5.9

It is recommended that the Ministry of Health and Long-Term Care provide educational resources to support the Ministry of the Attorney General in its provision of sufficient resources to the prosecution service in the Province of Ontario to ensure that specially trained Crown prosecutors with sufficient knowledge and skill to address the needs of mentally disordered accused persons and offenders are available in each Crown Attorneys Office.

5.10. CULTURAL DIVERSITY

Background

The criminal justice system consists of individuals from very culturally diverse populations. It is important that the health and criminal justice systems remain sensitive to cultural disparities.

Cultural competence is reflected in a set of congruent practices, attitudes and policies that work together in a service system. It is based on knowledge about cultural differences and worldview differences that affect cross-cultural interpretation, knowledge about the history, experience and consequences of prejudice, discrimination, and racism. It also includes knowledge about culturally specific beliefs about health and illness, biases and beliefs about culture, and stereotyped reactions to others.

Health and criminal justice systems must remain sensitive to cultural disparities

Without cultural competence, individuals of different races and cultures are subjected to different types of interventions within the criminal justice system. It impacts on how and why an individual is questioned by the police and / or arrested. It impacts on whether an individual is released on bail. It impacts on decisions made about which individuals need forensic assessments and / or treatment. It impacts at trial and at sentencing.

RECOMMENDATION 5.10

It is recommended that the criminal justice and forensic mental health systems:

- ***incorporate policies and practices that respect the diverse needs of individuals of different races and cultures;***
- ***allocate sufficient resources to meet the needs of this population; and***
- ***consult with appropriate agencies or other resources to provide education and training on cultural sensitivity which will impact on organizational changes and the delivery of treatment and services.***

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APPENDIX A

FORENSIC MENTAL HEALTH SERVICES EXPERT ADVISORY PANEL

INTERIM REPORT TO THE ONTARIO MINISTER OF HEALTH AND LONG-TERM CARE

JANUARY 28, 2002

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A. PANEL MANDATE

In January 2001, the Ontario Minister of Health and Long-Term Care established a Forensic Mental Health Expert Advisory Panel to consider province-wide operational issues in the context of existing policies and information, and to advise government on a provincial strategy for implementation of forensic services, specifically:

- Inter-ministerial coordination of forensic services;
- Consolidation and clarification of existing MOHLTC forensic policy; and
- Processes to improve services for forensic clients.

The Panel is to advise the Minister on the implementation and integration of forensic systems within mental health reform as set out in *Making it Happen* and related documents (e.g., *The Distribution of Mental Health Forensic Beds in Ontario*, *The Provincial Forensic System: Strategic Directions*) and the recommendations in the inter-ministerial report, *A Provincial Strategy to Coordinate Human Services and Criminal Justice System in Ontario.*

B. INTRODUCTION

As a general overview of forensic matters, most forensic mental health issues are subsumed under the expression of **"mental health and the law", defined as the branch of mental health sciences that deals with the interface between these sciences and the law**. It includes the assessment, management and treatment of mentally disordered persons in conflict with the law. Until February 1992, serious mentally disordered offenders were subject to the insanity provisions in the *Criminal Code (Canada)*. In 1992, the insanity provisions were repealed and replaced with Part XX.1 of the Code. The amendments in Part XX.1 extended the application of the Code's mental disorder provisions to less serious summary conviction offences and significantly extended the ability of courts to access mental health services based on the needs of the criminal justice system rather than clinical assessments of the accused person's condition.

The number of forensic clients has steadily increased over the past several years. This trend has resulted in an increase in demand for forensic services. This increase was predicted in a provincial forensic survey (*Forensic Psychiatric Clients in Ontario*, Rice, et. al., 1999). The exponential increase in forensic bed demand and utilization was predicted to have a significant impact on the availability of mental health beds for civilly committed clients. Although there has been an increase in forensic beds and services provincially (e.g., 97 additional forensic beds since 1995, court diversion, a Mental Health Court), the demand exceeds supply for forensic beds and services. For example, since the *habeas corpus* application was brought in 1998 which resulted in all clients with ORB Disposition Orders being transferred from jails and detention centres to their respective designated hospitals, the number of clients with Disposition Orders waiting for hospital beds has increased again. The lack of treatment options in jails, increased use of the health system by the courts, the segregation of forensic clients in health care facilities and the criminalization of the mentally ill also contribute to the increasing demand for forensic services. The criminalization of the mentally ill has also resulted in decreasing numbers of mental health beds being available to civil clients.

C. WORK TO DATE

1. Issue Identification

The Forensic Panel has taken a broad view of these issues in order to make recommendations to the Minister of Health and Long-Term Care. This interim report is intended to provide the Panel's preliminary views to the Minister of Health and Long-Term Care.

The Panel has identified multiple factors as barriers to the successful management of the forensic hospital and community system, including, but not limited to, the following (not prioritized):

1. A lack of co-ordination and accountability for how institutional mental health services are accessed and used by the criminal justice system. The demand for mental health services by the criminal justice system often is based on the needs of the criminal justice system rather than the needs of the mentally ill, particularly since 1992 when the insanity provisions were repealed and replaced with Part XX.1 of the *Criminal Code (Canada)* (supporting evidence will be provided in the Final Report to the Minister of Health and Long-Term Care).

2. An overuse of mental health services by the criminal justice system where the courts order multiple assessments, particularly for fitness to stand trial (supporting evidence will be provided in the Final Report to the Minister of Health and Long-Term Care).

3. The use of secure forensic beds for clients who could be managed in less secure settings, the general mental health system or the community. This problem, in part, results from the refusal of components of the mental health system to accept forensic clients which runs counter to government policy (*Making It Happen*) of "integrating lower-risk forensic clients into broader mental health services" (p. 56) and forensic policies (*The Distribution of Mental Health Forensic Beds in Ontario, The Provincial Forensic System: Strategic Directions)*.

4. A lack of relevant triage systems at the court level so that clients could be diverted from the justice system where appropriate, including the need to

have a mechanism that allows individuals who are the most in need (most dysfunctional and ill) to access the beds first (supporting evidence will be provided in the Final Report to the Minister of Health and Long-Term Care).

5. A poor understanding of definitions and forensic issues by individuals across ministries, professional disciplines and service providers. There is a need to develop definitions that are understood and endorsed by those involved in the field of forensics.

6. The stigmatization of mental health clients once they are labeled "forensic". An individual who acquires the "forensic" label is severely compromised in his/her ability to access opportunities (e.g., employment, housing) normally available to civilly committed clients and the general population. This stigmatization has had a direct impact on the lack of appropriate accommodation in the community for forensic clients who might otherwise be discharged from hospital (supporting evidence will be provided in the Final Report to the Minister of Health and Long-Term Care).

7. The refusal by many mental health agencies to accept forensic clients which is contrary to Ministry policy. Clinical staff in general psychiatric units often feel that individuals who need hospitalization and who are involved with the criminal justice system should be hospitalized in a forensic bed. General community psychiatrists are sometimes reluctant to accept referrals if the individual is before the courts because of their fear of possibly having to testify, write lengthy reports, liability issues, etc.

8. Access to long-term community supports is extremely difficult for forensic clients. Criteria for acceptance by community services (e.g., Assertive Community Treatment (ACT) Teams) are too restrictive and response to referrals is too long (supporting evidence will be provided in the Final Report to the Minister of Health and Long-Term Care).

9. Limited community alternatives for less serious mentally disordered offenders who might otherwise be diverted from the criminal justice system. The use of the mental health system by the courts and others in the criminal justice system to address the perceived social needs of persons in conflict with the law is problematic. Police need a third option besides arrest and hospitalization. There is not enough emphasis on pre-charge diversion and prevention based on accepted standards of practice (supporting evidence will be provided in the Final Report to the Minister of Health and Long-Term Care)

10. Inadequate pre-release planning of mentally ill clients from the correctional system and inadequate post-release community care by the Ministry of Correctional Services (MCS). Many inmates who suffer from a severe mental illness are re-integrated in the community without establishing links with

mental health community services and supports. The consequence is that these individuals end up requiring a mental health bed or enter the forensic stream (supporting evidence will be provided in the Final Report to the Minister of Health and Long-Term Care).

11. Inadequate resources for mental health court support services (supporting evidence will be provided in the Final Report to the Minister of Health and Long-Term Care). The volume within these programs is very high (especially in large urban areas).

12. Insufficient senior ministry (MAG, MOHLTC, MCS, MCSS) support to enforce adherence to existing policies and to oversee system change implementation (supporting evidence will be provided in the Final Report to the Minister of Health and Long-Term Care).

13. Lack of a coordinating body with a mandate to effectively direct adherence to inter-ministerial forensic policies and procedures.

2. Strategic Direction

The Panel has:

- Compiled a considerable set of documents pertaining to the development and deployment of forensic resources across the Province;
- Has reviewed the extant forensic policies and data from a number of different forensic services and best practice models in several of these services; and
- Has reviewed several other related documents, including Government position papers and initiatives.

Given the large volume of material and complexity of issues, the Panel concentrated on five categories of issues:

1. **Concepts and Definitions:** An examination of concepts and definitions as they relate to forensics to ensure that these are understood consistently by individuals across ministries, professional disciplines and service providers.

2. **Inter-ministerial Issues:** A review of issues across ministries, namely, Ministry of the Attorney General (MAG), Ministry of Health and Long-Term Care (MOHLTC), Ministry of Correctional Services (MCS) and Ministry of Community and Social Services (MCSS), to identify and address common issues.

3. **System Integration:** A review of the need for all aforementioned ministries to work collaboratively in addressing the needs of common clients and to

determine how best to achieve this as well as for MOHLTC to implement forensic services in an effective, efficient and seamless manner within the mental health system.

4. **Information and Data:** A review of the need for a Management Information System (MIS) that will address the day-to-day needs across forensic services in the province in real time, including the identification of an efficient and effective Information Technology architecture that will have the capability of being integrated into a broad mental health monitoring and evaluation system.

5. **Standardization:** A review of protocols for the assessment of fitness and criminal responsibility as well as the format and content of ORB Administrator's Reports for the purpose of standardization to increase consistency across forensic programs, and the identification of core forensic treatment and rehabilitation programs based on best practice models.

3. Achievements to Date

The following achievements (in the format of recommendations) have been realized:

1. Concepts and Definitions

Recommendation re Definition of a Forensic Client

The Panel resolved that, to become a forensic client, a person has to have a mental disorder, be in the criminal justice system and be dangerous. As such, a forensic client is defined as: "a person who is being dealt with by the court or the Ontario Review Board under Part XX.1 of the Criminal Code of Canada, and who suffers from a major mental disorder and is in conflict with the law".

Recommendation re When a Client Ceases to be a Forensic Client

A "forensic client" ceases to be "forensic" once the ORB grants the client an Absolute Discharge.

Recommendation re Definition of Forensic Beds

The Panel defines a:

- "Forensic Bed" as one that is "designated" as such, or one that is occupied by a forensic client; and
- "Designated Forensic Bed" means one bed so defined and designated by Government policy.

Recommendation re Forensic Bed Ratio Policy

The Ministry's forensic bed ratio policy should be reinforced as a minimum ratio, with a focus to significantly enhancing community services, such as diversion, housing, intensive case management, etc.

Recommendation re Forensic Bed Ratio

The Ministry's forensic bed ratio should be reviewed to determine whether the previously defined ratio of 3.8 forensic beds per 100,000 population accurately reflects current need.

Recommendation re Utilization of Designated Forensic Beds

The MOHLTC should issue a directive stating that Ministry-designated and funded forensic beds are to be utilized only by forensic clients on an ORB Disposition Order.

Recommendation re Court Ordered Assessments

All court ordered assessments should be considered as a direct support to a criminal investigation, therefore, they are to be funded by the court system (i.e., Ministry of the Attorney General). This would lead to an increase in responsibility and accountability by MAG for these criminal cases until they come under MOHLTC's jurisdiction (i.e., following a finding of guilt and requiring an assessment of Criminal Responsibility). If a hospital setting is required, the order should allow for the immediate return of the client following the completion of the assessment.

Recommendation re Assessments of Criminal Responsibility

Assessments of Criminal Responsibility are only to be agreed to for clients found guilty of a crime and then ordered by the court for such an assessment. The associated costs are to be covered by the court system (i.e., Ministry of the Attorney General). This would lead to an increase in responsibility and accountability by MAG for these criminal cases until such time they come under MOHLTC's jurisdiction. If a hospital setting is required, the order should allow for the immediate return of the client following the completion of the assessment.

Recommendation re Assessments of Fitness

Court ordered fitness assessments should be done "in custody" (i.e., within a jail or court setting). If a hospital setting is required, the order should allow for the immediate return of the client following the completion of the assessment.

2. Inter-ministerial Issues

Recommendation re Existing Government Policies

MOHLTC should reinforce existing forensic policies (*The Distribution of Mental Health Forensic Beds in Ontario*, *The Provincial Forensic System: Strategic Directions*) and the recommendations in the inter-ministerial report, *A Provincial Strategy to Coordinate Human Services and Criminal Justice System in Ontario*.

Recommendation re Local Forensic Coordinating Committees

The four partner Ministries (MOHLTC / MCSS / MCS / MAG) equally endorse and fund the establishment of the local forensic coordinating committees, a key mechanism as per the inter-ministerial report, *A Provincial Strategy to Coordinate Human Services and Criminal Justice System in Ontario*. The Mental Health Implementation Task Forces are encouraged to support these local / regional committees.

3. System Integration

Recommendation re Forensic Client Integration

Building on the success in achieving forensic client integration at Whitby Mental Health Centre (WMHC), Ministry policy that directs the principle of forensic client integration in non-forensic services (hospital and community-based) that also balances the mandate to serve non-forensic clients should be enforced. Forensic clients at a lower security risk should be accommodated in "designated forensic beds" located in other areas outside of a forensic unit provided that forensic expertise is available on a consultative basis, that staff have appropriate information about the care and management of forensic clients and proper financial arrangements could be negotiated with Government. The Ministry should strongly enforce the existing policy that a forensic label is not grounds to refuse admission to a required service. The Mental Health Implementation Task Forces are encouraged to reinforce this expectation.

Recommendation re Management of Forensic Clients in non-Forensic Mental Health Programs

The management of forensic clients at lower levels of risk regarding security should be managed by professionals who are not necessarily fully dedicated to a forensic program given that forensic expertise is not required across the spectrum of issues involving mental health and the law and forensic assessments.

Recommendation re Management of Forensic Clients in an Integrated Inter-Ministerial System

The Panel recommends that, when clients move from one system to another such as from mental health to prisons and vice versa, "follow-up" workers from the host/sending facility should maintain liaison with them whether they are in prison or in the community. This is considered even more important in light of the development of "super jails" which will tend to centralize prison management at a time when mental health systems are decentralizing. Proper discharge planning and thorough "follow-up" workers will be even more essential then.

Recommendation re Responsibility of the Forensic System's Support of the Mental Health System

The forensic system, as an important part of the overall mental health system (including community programs), has a responsibility to make itself available to other parts of the mental health system, especially for consultations and educational activities.

Recommendation re Assertive Community Treatment (ACT) Teams

The Ministry should evaluate the efficiency and effectiveness of the Assertive Community Treatment (ACT) Teams regarding selection criteria and timeliness in accepting diagnostically appropriate forensic clients.

Recommendation re Organization of Mental Health Services

The MOHLTC should simplify and disseminate the 20 Key Junctures from the inter-ministerial report, *A Provincial Strategy to Coordinate Human Services and Criminal Justice System in Ontario*, and organize forensic mental health services in accordance with these 20 Key Junctures.

Recommendation re Financial Resources for Forensic Programs and Services

The Ministry should ensure that forensic programs be funded equitably with other programs based on proportion of forensic clients.

Recommendation re Human Services and Justice Coordination Committees

The Panel recommends that the local Human Services and Justice Coordination Committees be strengthened and provided with resources to coordinate communication, joint problem-solving and planning efforts among health, criminal justice and developmental services organizations within specific regions/communities.

4. Information and Data (for future Panel discussion)

The Panel has charged the Provincial Forensic Directors Group (composed of Directors of the nine Forensic Psychiatric Services in the Province) to review and propose a Management Information System (MIS) that will address the day-to-day needs across forensic services in the province in real time, including the identification of an efficient and effective Information Technology architecture that will have the capability of being integrated into a broad mental health monitoring and evaluation system. The proposed MIS will be reviewed by various ministry branches/divisions (e.g., Finance and Information Management, Integrated Policy and Planning Division).

5. Standardization (for future Panel discussion)

The Panel has charged the Provincial Forensic Directors Group to review protocols for the assessment of fitness and criminal responsibility as well as the format and content of ORB Administrator's Reports for the purpose of standardization to increase consistency across forensic programs, and the identification of core forensic treatment and rehabilitation programs based on best practice models.

D. NEXT STEPS

The Panel will continue to review recommendations for all 5 categories of issues, with a focus on Information and Data (Issue 4) and Standardization (Issue 5).

A number of items have been discussed which have not yet resulted in proposed recommendations to the Minister. There are also a number of items that will require discussion over the next few months.

The following is a draft list of items (not prioritized) the Panel members are planning to address:

- The need for the Panel to develop a vision statement for forensic services in Ontario. For example such a statement could read: "A fully developed forensic system, comprehensive in scope, combining and effective balance of integrated and dedicated hospital and community based services consistent with current MOHLTC and inter-ministerial policies".

- The need for annual funding to support forensic research (e.g., best practices) and evaluation studies (process and outcome) and to identify funding sources (e.g., Ontario Mental Health Foundation).

- The need to develop a standardized planning cycle (e.g., rolling 5-year cycle to accommodate construction schedules) to continually review and update bed requirements and approvals for timely readjustments to the system to reflect population fluctuations in the regions.

- The need for 3rd party evaluation of each regional forensic program/service to evaluate adherence to MOHLTC policy, including core program components and adequacy of resources to fulfil regional/provincial role. Should consideration be given to including a specific forensic component to the hospital accreditation cycle?

- The need for a multi-year community investment plan that mandates core programs, court diversion, ACTT acceptance of forensic clients, etc.

- The need for the Ministry to implement equitable funding for forensic programs to ensure the creation of necessary community based services as per the forensic report ("Range of Dedicated Forensic Services in Ontario") currently being finalized by the Ministry and the Forensic Directors (report to be submitted to the Panel for review and consideration).

- The need for the Ministry to finalize plans for the provincial maximum secure facility. The Ministry should finalize plans for the replacement of the current outdated facility.

- The need for MOHLTC to formalize with MCS the expectation that the Correctional system fund and provide appropriate mental health services within its service system to minimize the need for end-of-sentence transfers to MOHLTC's mental health system.

- The need for the Ministry and the ORB to formalize a process whereby ORB Disposition Orders be worded in such a way as to provide forensic clients access to an immediately available forensic bed while awaiting a forensic bed in the most appropriate/preferred designated facility, thereby allowing for improved system cooperation and more timely client placements.

- The need for the Ministry to develop a state of the art Management Information System for all mental health service providers to electronically collect and report basic information, including annual operating plans / service agreements. Consideration should be given to develop a common database for use across the mental health system to more effectively determine service need, service utilization, client profile and outcome. This database should have the capacity to isolate information specific to the forensic population.

- The need for the Ministry to continue to show leadership through the chairing of a provincial forensic mental health services committee to advise on service implementation within the Ministry. In addition to this group having a mandate to specifically address current issues (e.g., barriers impeding the timely transfer of clients within the mental health system) and to conduct ongoing reviews of the forensic mental health system provincially, this group should also have the authority to effect change and implement decisions arising from issues addressed.

- The need for the Ministry to continue to show leadership through the re-establishment and chairing of a provincial inter-ministerial forensic services committee to advise on service implementation across ministries. In addition to this group having a mandate to specifically address current issues (e.g., barriers impeding the timely transfer of clients within the mental health and correctional systems, issues arising from the court system) and to conduct ongoing reviews of the forensic system provincially, this group should also have the authority to effect change and implement decisions arising from issues addressed.

- The need for the Ministry of the Attorney General to establish mental health courts in all locations across the province where warranted and for the Ministry of Health and Long-Term Care to assist in providing community support services. The Forensic Expert Panel should advise the MOHLTC and Ministry of the Attorney General on criteria for the establishment of such courts.

- The need for the Ministries of the Attorney General and Health and Long-Term Care to identify key strategic investments for court support services in order to expand the scope of the court support worker program and to ensure that there is full advantage taken of diversion opportunities where indicated.

- The need the Ministry of Correctional Services to assess the mental health needs of the population at the province's superjails and MOHLTC to provide clarification on its role.

- The need for MOHLTC to provide funding to increase the knowledge and expertise of mental health staff regarding forensic issues across the continuum of services.

- The need for MOHLTC to identify current forensic service expenditures on a regional basis and to take steps to ensure that there is an equitable distribution of resources based on a per capita formula.

- The need for MOHLTC to take the leadership to develop an inter-ministerial accountability framework for the forensic services system in the province that is consistent with the goals of a provincial accountability framework.

- The need to give high priority by the MOHLTC to fund increased forensic service capacity in regions where a full continuum of services does not exist.

- The need for the Panel to advise the MOHLTC on provincial forensic service priorities for the next five years and to develop a plan accordingly.

- The need for the Panel to reaffirm MOHLTC policy, outlined in "Making It Happen", "A Range of Regional Forensic Services (Draft)", and indirectly in "A Provincial Strategy to Coordinate Human Services and Justice Systems in Ontario 1999", that endorses the concept of implementation and provision of forensic services on a regional basis.

E. TIMELINE

The timeline to address the 5 categories is as follows:

1.	**September/October 2001**	**Definitions and Concepts**
2.	November/December 2001	Inter-ministerial Issues
3.	January/February 2002	System Integration
4.	March/April 2002	Information and Data
5.	May/June 2002	Standardization
6.	July/August	Wrap up

On behalf of the Forensic Mental Health Expert Advisory Panel, Dr. J. Arboleda-Flórez (Chair) will be submitting a final report to the Minister of Health and Long-Term Care in the summer of 2002.

APPENDIX B

RANGE OF FORENSIC SERVICES IN ONTARIO

Prepared by the Forensic Directors Group

May 2002

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A. INTRODUCTION

The purpose of the "Range of Forensic Services in Ontario" document is to provide recommendations prepared by the provincial forensic directors to the Minister of Health and Long-Term Care via the Forensic Mental Health Services Expert Advisory Panel. These recommendations establish common definitions and identify the range of forensic services in Ontario required to provide the quality of care and supports that leads to safe reintegration of mentally disordered accused and offenders into the least intrusive environment.

The basic structure of a comprehensive forensic service system for Ontario is outlined. This framework, which is consistent with government policy, must incorporate several facets of an integrated system that impact directly and indirectly on the efficient and effective delivery of forensic services throughout Ontario. As such, violence prevention and court diversion services are considered of equal importance to assessment, inpatient, outpatient, consultation and specialty services. The provincial coordination of forensic services is also integral to the development of a comprehensive forensic service system for Ontario.

Not all services described in this document exist at this time. A series of recommendations are provided in order to develop and implement a comprehensive forensic service system for Ontario that will meet the needs of the mentally disordered accused and offenders in the manner described.

B. RANGE OF FORENSIC SERVICES

A comprehensive forensic service system must incorporate a range of forensic services. These will define an integrated system that impacts directly and indirectly on the efficient and effective delivery of forensic services throughout Ontario. All components outlined below are necessary and integral to the development and implementation of a comprehensive framework.

1. VIOLENCE PREVENTION

1.1. Education

Education directed toward professionals and the community provided by Regional Forensic Programs and the Provincial Forensic Hospital will promote a better understanding of mentally disordered accused and offenders. This will assist in the mentally disordered accused and offenders' transition to, and acceptance by, the local community. A regional approach to education involving consumers, families, service providers, and interested citizens will promote community acceptance and responsibility. Effective communication links will be maintained with local media, school boards, government, citizen groups, agencies, consumer/survivor groups and other organizations. The Regional Forensic Programs and the Provincial Forensic Hospital will be resources to educational institutions engaged in training of individuals for careers in the health care sector. Educational services within the forensic/correctional area could be undertaken jointly with other ministries and with participating Academic Health Sciences groups.

1.2. Research

Regional Forensic Programs and the Provincial Forensic Hospital will be affiliated with recognized university Divisions of Forensic Psychiatry, or their equivalents, having joint responsibility for conducting forensic research, identifying best practices, and educating professionals (health, legal, correctional) in forensic mental health specialization. Regional Forensic Programs and the Provincial Forensic Hospital will endeavour to establish relationships with programs for the training of Allied Health Professionals (e.g., Psychologists, Nurses, Social Workers, Occupational Therapists). Each Regional Forensic Program and the Provincial Forensic Hospital will contribute to a forensic database for research purposes. The database will be consistent across all Regional Forensic Programs and the Provincial Forensic Hospital and provide part of a research network in forensic psychiatric services for the Province of Ontario. Research will include a focus on risk assessment, risk management, and ongoing clinical needs assessment in relation to dedicated forensic psychiatric programs. Treatment outcome measures, treatment programs and protocols should be in place in the different facilities that will facilitate best practices and promote the integration of research findings into practice. Each Regional Forensic Program and the Provincial Forensic Hospital will have representation on a Provincial Forensic Research Committee to review proposals and make recommendations that involve more than one region.

1.3. Case Management and Outreach

Numerous agencies and institutions provide supports and services in the community that have an indirect impact on criminal behaviour. Outpatient teams associated with general rehabilitation psychiatry services could provide community supervision and support for low risk forensic clients, or those at somewhat higher risk but with non-violent histories. The Regional Forensic Programs will be adequately resourced to provide the necessary consultation and legal liaison supports to teams engaged in this activity. Only the Regional Forensic Programs will supervise those clients at higher risk for re-offending. The utilization of Assertive Community Treatment Teams (ACTTs) may serve as an adjunct to services provided by Regional Forensic Programs to meet the community-based needs of forensic clients.

1.4. Community Forensic Psychiatric Consultation

Regional Forensic Programs and the Provincial Forensic Hospital will consider requests for specialized forensic consultation from professionals in private practice, community agencies (e.g., CMHA Programs) and governmental agencies (e.g., probation, dual diagnosis services, developmental disability service providers, corrections, court outreach services) with regard to matters having to do with the convergence of mental disorder and criminal conduct. Access to specialized forensic consultation is a valued resource for clinicians in non-forensic settings who are presented with clinical challenges involving such issues as risk for violence and / or sexual violence, fire-setting, and other behaviour likely to represent a significant threat to public safety. Timely access to consultation services is an important factor in the proper management of high risk clients.

2. COURT DIVERSION SERVICES

2.1. Administrative Diversion

The Regional Forensic Programs may be requested by the police and Crown Attorney to assist them in their efforts to divert/triage minor, non-violent, offenders who apparently suffer from a mental disorder. The objective of Administrative Diversion is to secure appropriate mental health services for individuals with particular clinical needs without invoking controls and sanctions available in the Criminal Code as well as to reduce repeat offending through treatment of the mental disorder. The diversion mechanisms will include the dropping or staying of charges, or other procedures available to the Crown Attorney or police. Persons subject to this process will not be appropriate referrals to a specialized Regional Forensic Program.

2.2. Clinical Diversion

Clinical Diversion will involve the evaluation of individuals, charged with a criminal offence, who present as having a mental disorder and may be certifiable under the *Mental Health Act* of Ontario. These individuals will be evaluated by a forensic clinician in the police cells, local court or detention centre. Those who may be candidates for involuntary hospitalization under the *Mental Health Act* may be referred directly to general psychiatry or in specific circumstances to the Regional Forensic Program (see below). Charges may be withdrawn or stayed by the Crown Attorney.

3. ASSESSMENT SERVICES

3.1. Forensic Assessment – No Hospital Admission

Regional Forensic Program and the Provincial Forensic Hospital psychiatrists, and / or other forensic clinicians, will undertake brief psychiatric assessment of mentally disordered accused in order to provide opinion evidence or consultation regarding the issues of Fitness to Stand Trial and need for hospitalization. These assessments may be undertaken at the request of the Crown Attorney or defence counsel, in the context of a fee for service consultation, or for the court in response to a Form 48 under Section 672.11 of the *Criminal Code* of Canada (CCC). The Regional Forensic Programs and the Provincial Forensic Hospital may offer limited psychiatric assessment, in response to a Form 48, at the hospital site or detention site. If the assessment is to be conducted at the hospital site, the accused will be transported from detention to the hospital and returned to detention the same day. Brief assessments do not involve inpatient hospital admission. However, if, in the opinion of the assessor, a more comprehensive inpatient assessment is required, this may be arranged pursuant to Section 672.11(a) CCC (i.e., to make a determination as to whether the accused is unfit to stand trial).

3.2. Forensic Assessment – Hospital Admission

The Regional Forensic Programs and the Provincial Forensic Hospital will assess mentally disordered accused who are subject to Orders of Assessment for Criminal Responsibility by the Court under Section 672.11(b) of the *Criminal Code* of Canada to make a determination as to "whether the accused was, at the time of the commission of the alleged offence, suffering from a mental disorder so as to be exempt from criminal responsibility by virtue of subsection 16(1)" (*Criminal Code* of Canada). Necessary resources required for these assessments include: sufficient inpatient beds to accommodate demand, specialized clinical staff to enable thorough assessments to be completed in a timely manner, access to medical diagnostic services and a physical plant that balances the health care and safety needs of the accused with the safety of co-clients, staff and the community. Mentally disordered accused who are subject to an Assessment Order for Criminal Responsibility will be admitted to hospital within 48 hours of the Order being endorsed by the Court. The Ministry of Health and Long-Term Care will ensure that the Regional Forensic Programs and the Provincial Forensic Hospital are adequately resourced to conduct timely assessments of all mentally disordered accused persons seen in courts within their referral area. Those clients who require a high security service for court-ordered assessments will be assessed at the Provincial Forensic Hospital.

3.3. Treatment Orders

The Ministry of Health and Long-Term Care will ensure that the Regional Forensic Programs and the Provincial Forensic Hospital are adequately resourced to ensure compliance with Treatment Orders of unfit persons under the *Criminal Code* of Canada.

3.4. Dangerous Offender Evaluations

Regional Forensic Services and the Provincial Forensic Hospital may provide Dangerous Offender evaluations on either an inpatient or an outpatient basis at the direction of the courts where resources and expertise permit.

4. FORENSIC INPATIENT SERVICES

Inpatient Regional Forensic Programs and the Provincial Forensic Hospital must have the flexibility to increase or decrease bed capacity as demand dictates. Failing to ensure this capability will only serve to continue the established practice of detaining mentally disordered persons in the correctional system when they are entitled, by lawful order, to be in hospital.

4.1. Short Term Crisis Management Service

On consent of all parties, inpatient beds will be available to provide short term treatment and management of mentally disordered offenders who present a high risk of serious reoffence due to illness (see also Temporary Medical Absence). The Ministry of Health and Long-Term Care will ensure that Regional Forensic Programs and the Provincial Forensic Hospital are adequately resourced to ensure the immediate admission of clients requiring a high level of specialized support that will see them safely through a period of behavioural and / or clinical crisis. This service will provide a higher level of static and dynamic security than could be offered by other non-forensic services and will be separate from those services.

4.2. Secure Short Term Assessment & Treatment

The Regional Forensic Programs and the Provincial Forensic Hospital will conduct assessments for fitness to stand trial, criminal responsibility and, where funding arrangements exist, dangerous offender evaluations on mentally disordered accused and offenders referred by the legal system. These services also may be provided based on a transfer payment funding system. Through the forensic application of behavioural sciences, this service will provide short to medium term, court ordered treatment or, on consent of all parties, treatment of mentally disordered offenders.

4.3. Medium Term Rehabilitation and Community Reintegration Service

Assessment and treatment facilities must provide step down transitional programming to support clients to achieve their optimal level of functioning. The Ministry of Health and Long-Term Care will ensure that each Regional Forensic Program will be adequately resourced to admit from court, or from any other facility, any person who becomes subject to a Disposition of the Ontario Review Board or Order of the court directing them to that service. Accused persons who are subject to such Orders will be admitted without delay. The Ministry of Health and Long-Term Care will ensure that Regional Forensic Programs are adequately resourced to serve the needs of their respective regions.

Rehabilitation and Community Reintegration Services is a program designed to facilitate return to community life at the earliest reasonable opportunity by the application of a psychosocial rehabilitation model of care. Forensic clients suitable for this service will be those who will be expected to have significant independent community access within two years of admission to the program, or those admitted immediately following a finding of Unfit or Not Criminally Responsible (NCR) and for whom placement decisions have not been finalized. Programs will emphasize close psychiatric support, relapse prevention, risk management, education, occupational and vocational preparation, and establishment and maintenance of social supports (see Community Supports). The physical plant will not require extensive perimeter security but will require adequate rehabilitation facilities and a staff complement sufficient to the intensive clinical work, and close supervision, required during the community reintegration phase of rehabilitation.

4.4. Provincial Forensic Hospital

Many mentally disordered offenders who have committed a violent crime and are at high risk of reoffending because of their mental illness require considerable time in a secure hospital setting. These clients require secure treatment and who are not suitable candidates for significant community access within two years. Consistent with Mental Health Reform initiatives and Ministry policy articulated in Making It Happen, this service will be provided at a single provincial site designated as the Provincial Forensic Hospital. The Provincial Forensic Hospital is a facility designed and resourced so as to provide for both privacy and significant freedom of movement within a secure perimeter for persons who are not permitted significant community access and who require interventions for the treatment and management of disturbed behaviour. Services provided by the Provincial Forensic Hospital will emphasize quality of life issues by ensuring access to a variety of diversional activities and by providing for access to a broad range of therapeutic, educational and vocational activities within the secure perimeter. Clinical program elements will emphasize insight into illness and risk factors, coping with anger and other high risk internal states, sexual preferences and other needs areas that require concentrated attention in the rehabilitation phase prior to the point when community access is considered possible without subjecting the public to unacceptable risk to their safety. Program development is with the collaboration of the provincial Academic Health Sciences programs and coordinated with other Regional Forensic Programs.

The Provincial Forensic Hospital also serves a small number of clients within the Ontario forensic system who represent uniquely difficult challenges for institutional care. These are clients who engage in behaviours such as repetitive institutional violence, represent very high risks for escape, engage in sexual predation within the institutional setting, engage in fire setting behaviour or are seriously regressed.

The Provincial Forensic Hospital has very high levels of both static and dynamic security and staff specifically trained and highly experienced with this client group.

5. CONSULTATION SERVICES

5.1. Consultation

Regional Forensic Programs will establish consultation/liaison services to inpatient units within their facilities and with other service providers in their respective regions, recognizing that these professionals have unique knowledge, experience and expertise which are of valuable assistance in the treatment of clients. Consultations should assist in facilitating timely treatment/management decisions by the consulting clinicians, thereby enhancing efficiency and reducing cumulative risk to the safety of others. The consultation process will generally not result in the transfer of clinical responsibility to the Regional Forensic Program. Regional Forensic Programs will offer forensic consultation for the purposes of assisting the consulting agent with case management, strategic planning, or public relations regarding the reintegration of persons with mental disorder into the community.

The Provincial Forensic Hospital will provide similar consultation and support to the Regional Forensic Programs.

6. OUTPATIENT SERVICES

6.1. Mobile Outreach

Regional Forensic Programs will have mobile outreach capacity sufficient to provide community support for forensic clients living in their respective regions.

6.2. Day Program

Day Programs will be offered in conjunction with existing programs provided within the overall Regional Forensic Programs.

6.3. Family Support

Regional Forensic Programs and the Provincial Forensic Hospital will maintain ongoing family support initiatives, including counseling and information sessions, education of families, limited outreach and assistance in maintaining contact amongst family members, recognizing that community tenure is more likely to be sustained and successful with a functioning family unit to provide support.

6.4. Transitional Community Residential Support

Length of stay in a hospital is, in many cases, directly related to difficulties encountered in finding appropriate community accommodation. Community housing assists clients to acquire the skills necessary for successful re-integration with the general community. Successful tenure in the community will reduce the likelihood of re-hospitalization during the critical first months of community placement.

Regional Forensic Programs will provide support and consultation to community mental health housing and support providers to facilitate safe re-integration of mentally disordered accused and offenders into the community.

7. SPECIALTY SERVICES

7.1. Specialty Clinics

Depending on staff expertise, some Regional Forensic Programs and the Provincial Forensic Hospital may operate specialty clinics, such as for sexual deviation, violence, impulse control disorders, fire setting, etc. A Regional Forensic Program may also offer other specialized services based on regional needs (e.g., specialty services for Aboriginal peoples). Such programs will be consistent with best practice principles. These specialty clinics may be made available to appropriate non-forensic clients and to other Regional Forensic Programs upon referral.

8. PROVINCIAL COORDINATION SERVICES

8.1. Provincial Forensic Planning/Coordination Committee

Each Regional Forensic Program and the Provincial Forensic Hospital will have representation on, and work in coordination with, a provincial forensic planning/coordinating structure. These committees will ensure the continued provision of necessary services and the coordination of those services in a provincial rather than regional manner.

8.2. Regional Forensic Planning/Coordination Structure

Each region may have a planning/coordinating structure to ensure the coordination of services between multiple sites served by a Regional Forensic Program and amongst the affiliated Academic Health Sciences groups in the region.

8.3. Regional Forensic Coordinating Committee

Each Regional Forensic Program will endeavour to maintain an active Regional Forensic Coordinating Committee (or Human Services and Justice Coordinating Committee). This committee will be comprised of representatives from agencies providing services to the forensic client population and may include police, Crown Attorney, community mental health agencies, local detention facilities, defence bar, probation and parole, the judiciary, etc. The purpose of this committee is to coordinate the provision of services to the benefit of the forensic client and community in such a manner as to make the most efficient use of available resources.

8.4. Provincial Forensic Database

Under the direction of the Provincial Forensic Planning/Coordinating Committee (see above), a database will be designed, constructed and maintained. A forensic database is a coordinated, continuously expanding repository of information on the forensic system and the persons receiving service from it. Subject to any confidentiality requirements, this database will be accessible to the Ministry of Health and Long-Term Care, Regional Forensic Programs and the Provincial Forensic Hospital contributing data to it, and will form a basis for research and planning initiatives.

C. RECOMMENDATIONS

The following recommendations are provided in an effort to develop and implement a comprehensive forensic service system in the Province of Ontario. These recommendations are consistent with and complement current government policy to provide the quality of care and supports that leads to safe reintegration of mentally disordered accused and offenders into the least intrusive environment.

1. **The Ministry of Health and Long-Term Care must clearly define the service responsibilities for Regional Forensic Programs. Resource requirements to support these programs in meeting the needs of heterogeneous, non-forensic client populations requiring the support of specialized forensic programs in each region must be identified. The non-forensic client populations include:**

A. High Risk/Violent Clients

The Regional Forensic Programs and the Provincial Forensic Hospital must be provided with additional dedicated bed capacity and suitable staffing enhancements to offer their services to civilly committed high risk/violent clients. A very small number of civilly committed persons are extremely dangerous. Among this group may be persons who have significant histories of predatory sexual behaviour, fire setting behaviour or extreme violence against others, and who are likely to be detained involuntarily for very lengthy periods of time. Regional Forensic Programs or the Provincial Forensic Hospital will endeavour to be of assistance with the management of high risk behaviours by offering consultation to programs/ physicians attending to these clients. In exceptional circumstances, where in the opinion of the Regional Forensic Program or Provincial Forensic Hospital the specialized expertise and / or physical resources of the provincial forensic system are the only current ones likely to prevent serious bodily harm to other persons, the client may be accepted on transfer to the Regional Forensic Program or, if appropriate, to the Provincial Forensic Hospital. In all cases of transfer, a written agreement will be in place authorizing the return of the client to the referring program/physician when, in the opinion of the Regional Forensic Program or Provincial Forensic Hospital, the client is a suitable candidate for return to the referring program/physician.

Regional Forensic Programs and the Provincial Forensic Hospital will accept referrals only for civilly committed individuals who are already on involuntary certificates and for whom a written agreement exists for repatriation.

B. Young Offenders

Clear delegation and definition of responsibilities for Young Offenders is required. The Regional Forensic Programs must be provided with additional dedicated bed capacity and suitable staffing enhancements to offer this service. Given the current state, Regional Forensic Programs have no provision and are not configured to provide these services for adolescents. Until such provisions are in place, all Young Offenders (adolescents) requiring inpatient services must be referred to the SYL APPS Youth Centre.

C. Probation/Parole

Where the probationer/parolee is seeking medically necessary health services, such services will be provided as an OHIP-funded service or may be supported through the base budget funding from the Ministry of Health and Long-Term Care.

Where the referral is made by the probation/parole officer or other agent of the correctional authority, and where the object of the referral is to treat criminogenic need for the purpose of reducing risk for re-offence, services to probationers /parolees will be supported through service contracts with federal or provincial correctional services.

D. Temporary Medical Absence

Clear delegation and definition of responsibilities for a Regional Forensic Program or the Provincial Forensic Hospital to provide services to persons serving provincial sentences who require brief admissions to a secure mental health facility during the course of their sentence is required.

Persons on Temporary Medical Absence from provincial correctional facilities may be admitted to a Regional Forensic Program or the Provincial Forensic Hospital on the consent of all parties.

2. **The Ministry of Health and Long-Term Care's integration policy, articulated in *Making It Happen*, must be adhered to by Regional Forensic Programs and their parent hospitals in order to increase the utilization of general psychiatry beds by forensic clients.**

A number of forensic clients do not require the specialized expertise/resources of a Regional Forensic Program. Some forensic clients should be integrated with general psychiatry programs as per Ministry policy. Protected/Integrated Bed Programs, which is an administrative device to achieve greater integration of lower-risk forensic clients in broader mental health programs, must be implemented by all health care facilities that have Regional Forensic Programs.

Regional Forensic Programs from which lower-risk forensic clients were referred do not continue to bear the responsibility for supervision and legal/administrative paperwork. This responsibility will fall more correctly to the person-in-charge and could be discharged by a person assigned to that task centrally within the facility. Transfers to non-forensic services should only be contemplated for persons:

- On custodial orders (with or without conditions) who do not have a history of significant violent offending; or
- Whose risk of violent offending, as assessed by a uniform accepted protocol, is considered as being low; or
- Subject to conditional discharge orders.

Clients transferred to non-forensic programs will become the clinical responsibility of that program. Requests for return to the Regional Forensic Program will be managed in the customary referral and consultation manner except where a revised Disposition requires placement in a Regional Forensic Program.

3. **The Ministry of Health and Long-Term Care must develop a method to determine the appropriate number of protected/integrated beds for each health care facility that has a Regional Forensic Program.**

In order to effectively implement the Ministry's integration policy articulated in *Making It Happen*, the Ministry must develop a method to determine the appropriate number of protected/integrated beds for each health care facility that has a Regional Forensic Program. Without this formula, significant continuous challenges from non-forensic programs will be offered to prevent the transfer of forensic clients and, consequently, will compromise the implementation of the Ministry's integration policy.

4. **The Ministry of Health and Long-Term Care must ensure that adequate resources are in place in order to implement an effective comprehensive forensic service system in Ontario.**

In order to provide these services in the manner described, the Ministry must ensure that adequate resources are assigned to the Regional Forensic Programs and the Provincial Forensic Hospital.

Specifically, this document acknowledges the specialized expertise of forensic clinicians in serving the needs of high-risk clients and proposes to systematize the historic *ad hoc* practice of treating high-risk civilly committed clients on forensic services. To undertake this additional responsibility, while at the same time discharging all other obligations responsibly, forensic programs must be provided additional beds and staff. These additional resources must be factored in decisions regarding minimum bed counts for each Regional Forensic Program and for the Provincial Forensic Hospital.

Consultation/liaison, Diversion, and Outreach services have historically been offered on an *ad hoc* basis. It is proposed in this document that these services, because of their value to clients and to the community and because they result in substantial resource savings over time, should become part of the Regional Forensic Service mandate. These additional responsibilities cannot be undertaken in the absence of specific considerations of the resource implications for each Regional Forensic Program. It is anticipated that investment in these services will result in substantial savings in other services provided by the mental health and judicial systems.

5. **A comprehensive plan for a coordinated provincial forensic system must be developed and communicated.**

   All forensic documents that have contributed to provincial forensic policy need to be coalesced to develop a comprehensive plan for a coordinated provincial forensic system for the Province of Ontario. The resultant policy document must be sanctioned by the Ministry of Health and Long-Term Care and communicated widely to ensure consistent implementation across the province.

6. **Services provided by Regional Forensic Programs must be coordinated.**

   Some type of provincial strategy/infrastructure and process is required for coordinating the provision of all forensic services throughout the province. This strategy/infrastructure should consist of an authoritative body to manage all forensic issues to enhance efficiency and effectiveness in the delivery of services to forensic clients.

7. **In order to provide the least restrictive environment for forensic clients, the security provided by Regional Forensic Programs must be clearly defined and standardized.**

   Forensic clients in Ontario will reside in facilities providing the least restrictive environment consistent with public safety. Those clients not requiring hospitalization will reside in community accommodation. While living in the community, these clients will be monitored by hospital staff external to the Regional Forensic Programs. Those clients whose level of risk requires hospitalization but not secure custody will reside in general psychiatry rehabilitation programs at general or tertiary care facilities. Those clients whose level of risk requires secure custody but who do not represent serious institutional management problems will be placed in the appropriate Regional Forensic Program. Those clients representing high security risk and / or who present with serious institutional management problems, or who require longer-term secure care, will be placed in the Provincial Forensic Hospital.

8. **Standardized modular treatment programs that each Regional Forensic Program and the Provincial Forensic Hospital will offer must be developed.**

   Through a provincial forensic coordinating structure (see above), standards (best practices) will be established and implemented with annual review for programs and services offered across the provincial forensic system. These programs and services may include: risk assessment and management, case preparation for Ontario Review Board hearings, needs assessment, program evaluation, clinical program elements, and standardization of static and dynamic security.

9. **Forensic bed distribution in Ontario must be based on valid and current information.**

   The appropriate sizing and configuration of the Ontario forensic mental health system can be determined only following consultation with all stakeholders and the accumulation of valid demographic, demand, and utilization data in addition to projection of future trends. Currently available data are not sufficiently up to date, or sufficiently comprehensive, to justify decisions that may be based on them. Stakeholders in this context will include, but may not be limited to, the courts, the Ministry of the Attorney General, the Ministry of the Solicitor General, the Ministry of Community and Social Services, the Ministry of Correctional Services, Forensic Program Directors, the Ontario Review Board, and Academic Health Sciences Centres affiliated with the Ontario forensic system.

10. **Research and Education must receive priority by Regional Forensic Programs and the Provincial Forensic Hospital and the resources and funding options need to be identified.**

    Research and education are both vital elements in sustaining quality of service at traditional high levels. The provincial forensic coordinating structure (see above) should establish a subcommittee to address system research and training requirements. Sufficient fiscal resources should be invested in research of forensic issues and education/training of direct services staff to ensure the ongoing evolution of quality clinical services to clients and risk management services offered on behalf of the community. Specific funding allotments should be identified. These should be reviewed annually.

APPENDIX C

PART XX.1 / MENTAL DISORDER CRIMINAL CODE (CANADA)

A Brief History and Overview

In 1991, the Supreme Court of Canada struck down the insanity provisions of the Criminal Code (Canada) on constitutional grounds.[1] The court directed the Federal Government to enact new legislation for the supervision of the mentally disordered accused within six months of its decision. The new legislation was introduced as Bill C-30 and was enacted by Parliament, and proclaimed in force on February 4, 1992, as Part XX.1 / Mental Disorder of the Criminal Code (Canada).

Part XX.1 / Mental Disorder

Part XX.1 modernized some of the language that had been used in the Criminal Code for over 100 years. For example: the term "not guilty by reason of insanity" was changed to "not criminally responsible on account of mental disorder".

Under the insanity provisions, a person found not guilty by reason of insanity was automatically detained in strict custody "at the pleasure of the Lieutenant Governor". Automatic strict custody was eliminated in Part XX.1. Instead, the court was empowered to hold a disposition hearing immediately following a verdict of not criminally responsible and to make its own disposition for the accused[2]. The possible dispositions include an absolute discharge, a conditional discharge or custody in a hospital designated by the Minister of Health for a province.

Assessment

Part XX.1 permits the court to order an assessment of the fitness of the accused to stand trial or an assessment of the criminal responsibility of the accused person at any stage of the proceedings, on the court's own motion or on the application of the accused or the Crown. (There are some restrictions on when assessments can be ordered on the application of the Crown.)

While Part XX.1 provides that assessments should be presumed to take place out of custody, in reality the majority of assessments are conducted in custody. In many courthouses in Ontario, programmes are in place where psychiatrists assess the accused at the courthouse without the necessity for a hospital stay. In jurisdictions where this service is not available, the accused is generally remanded for a five to thirty day assessment at a hospital.

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[1] *R. v. Swain*, [1991] 1 S.C.R. 933

[2] Part XX.1 uses the term "accused" when referring to persons who have been found unfit to stand trial or not criminally responsible for an offence on account of mental disorder.

Assessments may also be ordered by the court for the purpose of determining the appropriate disposition. Such assessments cannot currently be ordered by the Review Board[3].

Verdicts of unfit and not criminally responsible

The terms "unfit to stand trial" and "not criminally responsible" are defined in the Criminal Code as follows:

> Unfit to Stand Trial: means unable on account of mental disorder to conduct a defence at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, and, in particular, unable on account of mental disorder to
> (a) understand the nature or object of the proceedings,
> (b) understand the possible consequences of the proceedings,
> (c) communicate with counsel.
>
> Not Criminally Responsible: No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong.
>
> Mental Disorder: means a disease of the mind.

If the court returns a verdict that the accused is unfit to stand trial or not criminally responsible ("NCR"), but does not hold a hearing or make an initial disposition, the accused remains subject to any order for his or her custody or judicial interim release in existence at the time of the verdict. This could include an existing or a varied bail order, or an order for the accused's custody in jail or in a hospital, pending an initial disposition by the Review Board.

Treatment

There is only one very narrow window of opportunity for the imposition of involuntary treatment within provisions of Part XX.1; that is, by a **court** upon a verdict of unfit to stand trial, and prior to the making of a disposition pursuant to s.672.54. However, terms related to treatment may be included in a disposition with the accused's consent. Where consent is withdrawn subsequent to the issuance of such a disposition, the term becomes inoperative but may cause one of the parties to seek a review of the disposition.

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[3] The *Response of the Minister of Justice to the 14th Report of the Standing Committee on Justice and Human Rights (November 2002)* states that the Government intends to table a package of amendments to Part XX.1 of the *Criminal Code* which would include amendments to permit a Review Board to order an assessment where necessary to make a disposition and where no current assessment is available.

Review Boards

The role of the Lieutenant Governor has been eliminated in Part XX.1. The Lieutenant Governors' "advisory" boards, which existed prior to 1992, were converted into adjudicative boards whose responsibilities were expanded to the actual making of the order, now referred to as a "disposition".

The Review Board[4] has jurisdiction over individuals who have been found by a court to be either unfit to stand trial or not criminally responsible for an offence on account of mental disorder. The Board is an independent tribunal established pursuant to Part XX.1. This part of the Criminal Code stipulates that each province and territory must establish or designate a Review Board to oversee these individuals.

Members of the Review Board are appointed by the Lieutenant Governor in Council for each province. An order-in-council is issued for each member appointed to the Board. Although the Board is created pursuant to the provisions of the Criminal Code (Canada), a federal statute, the Code expressly provides that the Board is to be treated as "having been established under the laws of the province".

The Review Board must consist of no fewer than five members. Part XX.1 provides that at least one member of the Board must be qualified to practice psychiatry and, in the event there is only one such member, one other member must have training and experience in the field of mental health and be entitled to practice medicine or psychology.

With the proclamation of Bill C-30, a quorum of the Board consists of the Chairperson, a psychiatrist and "any other member". The Chairperson must be a judge of the Federal Court or of a superior, district or county court of a province, or a person who has retired from or is entitled to be appointed to such a judicial office (i.e. a lawyer with 10 years experience). "Chairperson", by definition, includes not only the Chairperson as appointed by Cabinet, but also any other qualified member designated by the Chairperson as an "Alternate Chairperson".

Generally speaking, the Ontario Review Board sits in panels of five and most panels of the Board include a community member who is neither a lawyer nor a health care professional.

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[4] As a result of efforts led by the Honourable Douglas H. Carruthers, Chair of the Ontario Review Board, the Review Boards in each Canadian jurisdiction are clearly identified in a uniform manner; ie the British Columbia Review Board, the Alberta Review, the Nunavut Review Board, etc..

Hospitals

For the purposes of Part XX.1, 'hospital' has been defined as:

> a place in a province that is designated by the Minister of Health for the province for the custody, treatment or assessment of an accused in respect of whom an assessment order, a disposition or a placement decision is made.

The list of designated hospitals[5] in Ontario is as follows:

Royal Ottawa Health Care Group (Brockville Psychiatric Hospital Division)

Centre for Addiction and Mental Health

St. Joseph's Healthcare, Hamilton,
Centre for Mountain Health Services

Providence Continuing Care Centre, Mental Health Services
(formerly Kingston Psychiatric Hospital)

Lakehead Psychiatric Hospital

Regional Mental Health Care London,
St. Joseph's Health Care London

Mental Health Centre, Penetanguishene

North Bay Psychiatric Hospital

Royal Ottawa Health Care Group
(Royal Ottawa Hospital Division)

Regional Mental Health Care St. Thomas,
St. Joseph's Health Care London

Whitby Mental Health Centre

Thistletown Regional Centre for Children and Adolescents (Syl Apps)

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[5] The hospitals designated by the Ontario Minister of Health and Long-Term Care under Part XX.1 also are designated psychiatric facilities under the *Mental Health Act*, R.S.O. 1990, c. M.7 (as amended).

Review Board Hearings[6]

Review Board hearings are open to the public, subject to the Board's discretion to exclude the public, where it considers it to be in the best interest of the accused and not contrary to the public interest.

In Ontario, most, hearings are held in the hospital where the accused is detained or required to report. On some occasions a hearing (particularly an initial hearing) may be held in a court house or a jail. For the Greater Toronto Area, as of May 1998, most hearings that would otherwise have been held in a jail are being held at Courtroom #114 at the Old City Hall Court House. This special court for the mentally disordered accused servicing the Greater Toronto Area, has been operational since May 1998 and provides space for the Ontario Review Board to conduct its hearings one day per week.

When a hearing is conducted in a hospital it is usually in a boardroom or other similar setting. Hearings before the Ontario Review Board are informal and, while often contentious, are not strictly adversarial in the same sense that a criminal or civil trial is adversarial. Evidence may be, but rarely is, taken under oath.

If the hearing is to deal with an accused who has been found unfit to stand trial, the Criminal Code provides that there must be counsel representing him or her at the hearing. If such an accused appears before the Board unrepresented, arrangements must be made to have counsel appointed before the hearing can continue. The same requirement applies in respect of unrepresented accused who have been found NCR wherever, in the opinion of the Board, the interests of justice so require.

The Parties

The three parties at most Ontario Review Board hearings are the accused, the person in charge of the hospital where the accused is in custody or required to report, and the Attorney General. Generally speaking, the parties at a court's disposition hearing are limited to the accused and the Attorney General. Individuals who have a "substantial interest in protecting the interests of the accused" may be designated as parties by the court or Review Board. Where the accused is a "dual status offender" [described below] the Solicitor General of Canada or the Minister of Correctional Services becomes a statutory party for federal and provincial inmates, respectively. Most accused are represented by counsel, as is the Attorney General.

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[6] In 2001, the Ontario Review Board held 1301 hearings.

Evidence

Normally, evidence before the Review Board consists of the oral testimony made by the parties' witnesses and any documents filed with the Board as exhibits. All witnesses called may be subject to cross-examination. The Criminal Code requires that the proceedings be recorded.

A Review Board may make rules providing for the practice and procedure before the Board. These rules, made pursuant to s. 672.44(1) of the Criminal Code, may be published in the Canada Gazette and will apply to any proceeding within the Board's jurisdiction unless specifically overruled by regulations in respect of practice and procedure made by the Federal Government.

The Ontario Review Board has Rules of Procedure which all parties are required to follow at every proceeding held by the Board. It is the Board's practice, some two weeks or so prior to the date of a hearing, to send a copy of the Board's record and new disposition information to each member scheduled to preside at an upcoming hearing, as well as to all of the parties. That record will include a copy of the current disposition and the Board's reasons for disposition, if they exist.

In addition, the disposition information at an Ontario Review Board hearing will usually include a copy of the hospital administrator's up-dated annual report and the administrator's recommendations to be considered at the upcoming hearing.

Dispositions

Three disposition options are available for an accused who has been found NCR and two options are available for an unfit accused. The disposition options and the Review Board's jurisdiction at a disposition hearing are set out in s.672.54 of the Code, as follows:

> Where a court or Review Board makes a disposition pursuant to subsection 672.45(2) or section 672.47, it shall, taking into consideration the need to protect the public from dangerous persons, the mental condition of the accused the reintegration of the accused into society and the other needs of the accused, make one of the following dispositions that is the least onerous and least restrictive to the accused:
>
> > (a) where a verdict of not criminally responsible on account of mental disorder has been rendered in respect of the accused, and in the opinion of the court or Review Board, the accused is not a significant threat to the safety of the public, by order, direct that the accused be discharged absolutely;
> >
> > (b) by order, direct that the accused be discharged subject to such conditions as the court or Review Board considers appropriate; or

> (c) by order, direct that the accused be detained in custody in a hospital, subject to such conditions as the court or Review Board considers appropriate.

In the case of an accused who has been found unfit to stand trial, the court retains residual jurisdiction over the accused who must be returned to court, if and when he or she becomes fit. Therefore, an absolute discharge is not an option for an unfit accused.

The Review Board's jurisdiction over an unfit accused is maintained only so long as he or she remains unfit. The intention of the scheme outlined in the Criminal Code is that persons declared unfit to stand trial will return for trial when they are found fit to do so. The Crown, in the meantime, must satisfy the court at two year intervals that it possesses sufficient evidence to put the accused on trial.

Pursuant to Part XX.1, the Review Board shall, by order, direct that a NCR accused be absolutely discharged, where the Board is satisfied that "the accused is not a significant threat to the safety of the public". The Supreme Court of Canada, in R.v.Winko[7], has indicated that, unless there is a positive finding that the accused is a significant threat to the safety of the public, an absolute discharge must be granted by the court or the Review Board.

If the court or Review Board finds affirmatively that an accused is no longer a significant threat to the safety of the public, and as a result, absolutely discharges the accused, then he or she is no longer subject to review. His or her obligations to the criminal justice system are thereby concluded.
If the accused is found to be a significant threat to the safety of the public, or if the accused is unfit to stand trial, two dispositions are available to the Review Board: a conditional discharge or custody in a hospital, with appropriate conditions. Conditions may include community access or residence in the community.

Where the Board makes a disposition for the accused's conditional discharge and the accused is required to report to the person in charge of a designated hospital, or where the Board makes a disposition for the accused's custody in a hospital, it may delegate its authority to the person in charge to increase or decrease the restrictions on the liberty of the accused, within any limits or subject to any conditions set out in the Board's disposition.

A majority vote of the panel determines the disposition that is to be made at a hearing.

The Review Board must give written reasons for each disposition.

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[7] *R. Winko*, [1999] 2 S.C.R. 625

Review Board Proceedings

The proceedings held by a Review Board under Part XX.1 include: initial disposition hearings for unfit and NCR accused, annual reviews of dispositions, additional mandatory or discretionary reviews, placement hearings and transfer applications.

The Board must hold a hearing and make an initial disposition within forty-five days of the court's verdict of NCR or unfit to stand trial. This period may be extended to ninety days, if the court already has made a disposition.

Section 672.81 of the Criminal Code requires the Review Board to hold a hearing not later than twelve months after making the initial disposition and every twelve months thereafter, for as long as the disposition remains in force.

In addition to the "initial" and "annual" hearings mentioned above, there are provisions in Part XX.1 to allow for other disposition hearings. These ad hoc hearings may be triggered by the hospital administrator's request (a mandatory hearing), the request of one of the other parties (a discretionary hearing), or where the accused's liberty has been significantly restricted for a period of more than 7 days (a mandatory hearing).

The procedures and the Board's jurisdiction are the same for all disposition hearings and hearings to review a disposition.

Finally, there are two other sorts of hearing held by the Board - placement hearings and applications for interprovincial transfer.

"Placement hearings" are held annually for all "dual status offenders".
A "dual status offender" is an offender who is subject to a sentence of imprisonment in respect of one offence and a custodial disposition under s.672.54(c) in respect of another offence. The decision to be made at a placement hearing is whether the accused should be detained in prison or in a hospital.

An accused may also apply to the Board where he or she wishes to move to another province. The Board's jurisdiction in such cases is limited to making a **recommendation** regarding transfer. The actual decision to transfer [or not] is made subsequent to the recommendation of the Review Board, by the Attorneys General of the sending and receiving jurisdictions.

Appeals

The right of appeal from a court's or Review Board's disposition is directly to the Court of Appeal for the province or territory where the disposition is made. The Court of Appeal is required to hear the appeal "as soon as practicable," after the day on which the Notice of Appeal is filed and within any period that may be fixed by the Court of Appeal.

APPENDIX D

DESCRIPTION OF ONTARIO'S CURRENT FORENSIC SERVICES

A. Overview of Forensic Mental Health System

The role of Ontario's forensic mental health system is based Part XX.1 / Mental Disorder of the *Criminal Code (Canada)*. These provisions spell out a range of options for dealing with an accused person appearing before a Court who has (or is thought to have) a mental disorder. The Code specifies that, where detention in custody is necessary to address these issues, the accused may only be detained in a hospital designated by the Minister of Health and Long- Term Care.[8] In Ontario, the Minister has designated six mental health facilities and four Provincial Psychiatric Hospitals (PPHs) / Mental Health Centres. PPHs are operated by the Ministry of Health and Long-Term Care (MOHLTC). The others operate within the confines of their respective corporations legislation, governance mandates, bylaws, policies and procedures.

Forensic services are provided throughout Ontario. The provincial forensic mental health system consists of a broad continuum of mental health services, ranging from secure inpatient settings to integrated mental health programs and community services and supports. It is comprised of dedicated forensic mental health services and integrated mental health beds. Programs and services serving the seriously mentally ill are also provided through a number of Schedule 1 health care facilities and a variety of community-based agencies.

As of October 22, 2002, Ontario's Ministry of Public Safety Security (MPSS) records indicate that 11.2% of their inmate population show mental health flags that indicate that a mental health issue has been identified. The actual proportion of inmates with mental illness is in the 15% to 20% range. The proportion of inmates with a serious mental illness approximately 6% to 8%.

MPSS records also indicate that, on the same date, they had 8,995 (4,301 remand; 4,694 sentenced) beds / cells staffed and in operation under their jurisdiction across the province. A total of 561 of these beds / cells are designated as Special Needs beds. These beds are not all occupied by mentally ill inmates; they also accommodate inmates with: physical illness, addictions problems, HIV / AIDS, and special offences (e.g., sex offences). Plans are reportedly in place to add 50 new Special Needs beds in the Near North and 100 in the South East during 2003/04.[9]

In 1997, the MOHLTC, in partnership with the Ministry of Community, Family and Children's Services (MCFCS), the Ministry of the Attorney General (MAG), and the

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[8] The Provincial Forensic System. MOHLTC, Ontario. April, 1997; p.3.

[9] Presentation to Mental Health Implementation Task Forces. Phillips, M., Ph.D., Ministry of Public Safety and Security. 2001/02.

Ministry of Public Safety and Security (MPSS) developed a provincial forensic strategy. This provincial forensic strategy was to be the policy blueprint for all operational and policy initiatives concerning people with mental disorder and / or developmental disability, who come in conflict with the law. It was intended to guide both inter-ministerial and ministry-specific initiatives. The four inter-ministerial agreements arising therefrom were not approved by all ministries concerned.[10] The MOHLTC also developed forensic strategic directions and a bed distribution plan. Both MOHLTC documents were adopted as policy. Initiatives based on this work continue to surface through the goodwill and commitment of service providers and the MOHLTC.

B. Dedicated Forensic Mental Health Services

1. Description of Programs / Services

Dedicated forensic mental health programs / services are currently provided through the 10 designated facilities situated in communities throughout Ontario. All 10 forensic programs are funded by the MOHLTC.

These designated facilities provide services to mentally disordered offenders in the following ways:

1. by undertaking assessments of accused persons: to establish if mental disorder is a current issue; to assist the court in determining whether the person is fit to stand trial and / or qualifies for a not criminally responsible defence at trial;
2. by detaining and treating individuals who have been found unfit to stand trial or not criminally responsible (NCR); and
3. by admitting and treating offenders from the correctional system where their condition is acute enough to warrant care in a mental health facility.

MOHLTC's mandate is operationalized within parameters that include:

1. treatment and / or management must occur in the least restrictive and most humane environment that is clinically and legally prescribed;
2. humane treatment must be balanced against the need to protect staff and others in the institution and community from potential harm by the forensic client;
3. the designated facilities have accepted, as a major goal, the successful assessment, treatment, rehabilitation and, where possible, safe integration of forensic clients into the community, at the most independent level possible; and

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[10] Ministry Commitments: Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario. MOHLTC. 2000; p.1.

4. with forensic inpatients, who present a low risk of re-offending, the preference is to integrate them into general psychiatric programs, including those in community settings.[11]

2. Data Collection

Currently, Ontario does not have a standardized forensic mental health data collection system. Consequently, forensic mental health information is sparse.

At times, operational definitions of key forensic mental health terminology vary from agency to agency.

In an effort to at least be current in their knowledge of the MOHLTC's dedicated forensic mental health programs / services, Ontario's Forensic Mental Health Services Expert Advisory Panel commissioned a Snap Shot Survey in 2002. The survey queried all 10 of the designated facilities about their forensic bed / service capacity, utilization, staffing, costs, clinical programming, and key issues.

The Survey did not include Schedule 1 facilities or community-based agencies. Consequently, no survey data were available to help the Panel determine service capacity, utilization, staffing, costs, clinical programming or key issues for these facilities. The same limitation applies to forensic mental health services / programs provided by the police, courts, jails, detention centres and social services agencies.

3. Forensic Beds

A. Capacity

i. Non-Forensic Mental Health Beds

In 1999, the Health Services Restructuring Commission (HSRC) accepted a mental health bed ratio of 37 beds per 100,000 adult population for the year 2000. The ratio included 21 acute beds and 16 specialized treatment beds. The HSRC also accepted the MOHLTC mental health reform bed ratio target of 35 beds per 100,000 adult population by 2003 (21 acute beds and 14 specialized beds). The longer-term bed ratio is 30 beds per 100,000 adult population (18 acute and 12 specialized). The HSRC also established a bed ratio of 7 beds per 100,000 population (0-17 years of age). The MOHLTC accepted these ratio targets. The HSRC recommended that MOHLTC develop a forensic bed strategy, including bed ratios.[12]

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[11] The Provincial Forensic System. MOHLTC, Ontario. April, 1997; p.3-4.

[12] Mental Health Bed Analysis. MOHLTC, Ontario. January 6, 2000; p.1.

ii. Dedicated Forensic Mental Health Services

a. Regional Forensic Beds

The MOHLTC forensic bed distribution plan was approved in early 1999. The plan calls for a dedicated regional secure bed ratio of 3.8 per 100,000 adult population.[13]

The results of the Panel's Snapshot Survey suggest that mental health facilities currently staff and operate a total of 568 designated secure (140 Long-Stay / Maximum Secure beds and 428 Regional Forensic beds) and 158 protected / integrated beds. The total number of approved forensic beds (Long-Stay / Maximum Secure beds and Regional Forensic beds) in operation as of December 2002 is 568. The Centre for Addiction and Mental Health (CAMH), in their response to the survey, included 31 "minimum" secure beds in their count of designated secure beds. However, these 31 beds are not included in the count for Regional Forensic beds since they were not identified as such in the provincial strategic plan. Similarly, a 25-bed unit at Whitby Mental Health Centre (WMHC) which is occupied solely by forensic clients is not included in the count for Regional Forensic beds since these 25 beds also were not identified in the provincial strategic plan.

The MOHLTC, in its forensic bed distribution planning process, used 9.89 million adult Ontarians as the population under study in their calculation of bed ratios. With that same population in mind, the 568 designated secure beds (i.e., Long-Stay / Maximum Secure and Regional Forensic beds) represent a bed to population ratio of 5.7 beds per 100,000 adult Ontarians.

In accordance with the forensic bed distribution plan, funds have been allocated and plans activated to add the remaining 89 new designated Regional Forensic to the existing complement by 2003. At that point, these facilities will be operating a total of 657 staffed and funded designated secure beds and possibly 158 protected / integrated beds, resulting in a total of 815 beds occupied by forensic clients.

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[13] Ibid. p.1.

b. Protected / Integrated Beds

The bed distribution plan and *Making It Happen*, as policy documents, formally acknowledge the importance of protected / integrated mental health beds for forensic clients. These protected / integrated beds are designed to function as a means of serving forensic clients who are clinically stable and are able to be managed outside a secure forensic unit. With increased access to these beds for these clients, it is envisioned that access to secure beds would be enhanced for those clients waiting in jail or in the Provincial Forensic Hospital who should be transferred to lower levels of security.[14]

In January of 2000, a ratio based on historical utilization patterns and predicted trends of 3.0 protected / integrated forensic beds per 100,000 adult population was proposed. This ratio resulted in an identified need for 298 protected / integrated beds. Estimates indicated that it would cost $50 less per day for someone to use a protected / integrated bed in lieu of a designated forensic bed.[15] To date, no adjustment in protected / integrated forensic bed funding or base has occurred.

The results of this Snapshot Survey suggest that, generally, mental health facilities do not provide protected / integrated beds. Bed availability is provided on a "first come, first served basis", regardless of legal status. Many of the survey respondents are concerned that, without the specific designation and funding of protected / integrated forensic beds, this growing forensic client population will continue to utilize the existing specialized / longer term mental health beds (part of the HSRC bed ratio). When coupled with the HSRC's recommended reduction of mental health beds, this heightens concerns with respect to continued access problems for the non-forensic seriously mentally ill who require inpatient treatment.

B. Utilization

i. Flow Into Facility

a. Regional Forensic Beds

The Snapshot Survey results also suggest that, at any point in time, at least 84 forensic clients may be awaiting admission for a Regional Forensic bed for up to one year from the judicial system or transfer from another Regional Forensic Program.

The judicial system and the Ontario Review Board have grown increasingly impatient with and unsympathetic to the mental health facilities' waiting lists. Members of the criminal justice system have resorted to various legal venues to get these clients in hospital beds. Some courts and defence lawyers invoke a specific clause in the Criminal Code of Canada that renders the date an order is made as the required effective date of admission. A forensic client, with such an order, is able to be admitted ahead of others on the waiting list. The Ontario Review Board may stipulate admission either immediately or within a few days. Detention centres are very aware of their lack of authority to detain people whose detention order stipulates custody in a health care facility.[16]

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[14] Mental Health Bed Analysis. MOHLTC, Ontario. January 6, 2000; p.1,3.

[15] Mental Health Bed Analysis. MOHLTC, Ontario. January 6, 2000; p.1,3.

The Survey failed to determine the number of clients admitted to a Regional Forensic bed during a consecutive 12-month time frame for 2001/02. The respondents generally agreed that the “flow in” (admission to the facility) of forensic clients would be relatively close to the “flow out” (discharge / transfer out of facility), approximately 882 clients.

b. Protected / Integrated Beds

The Survey was unable to determine a waiting list for admission of forensic clients directly to protected / integrated beds. Utilization data were also unavailable with respect to “flow into” these non-designated beds during a consecutive 12-month time frame for 2001/02.

ii. Occupancy and Flow Through the Facility

a. Regional Forensic Beds

The snapshot findings further suggest that designated Regional Forensic beds, at any point in time, are 97% occupied, predominantly by 20 - 65 year old (92%) males (89.8%), with the majority (55.4%) having resided in a designated Regional Forensic bed for 2 years or less. Most of the facilities (90%) reported that, at any point in time, 23 (4.5%) of their forensic inpatients in Regional Forensic beds may be awaiting transfer to another bed within their respective facility, with the majority (91.3%) waiting for 1 year or less. Most of the facilities (90%) also reported that, at any point in time, 34 (6.9%) of their forensic inpatients in Regional Forensic beds may be on an approved leave of absence from their respective facilities. The majority (55.9%) of these clients may be absent for 1 month or less. These clients, while on leave, are assured access to their original bed should they require re-admission.

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[16] The Provincial Forensic System. MOHLTC, Ontario. April, 1997; p.7.

b. Protected / Integrated Beds

The survey results suggest that, in the absence of protected / integrated forensic beds, 9 (90%) of these facilities, at any point in time, may be using 158 (or more) of their general mental health beds to accommodate forensic clients. The results also suggest that, at any point in time, 100% of these protected / integrated beds may be occupied, predominantly by 20 - 65 year old (83.6%) males (88%), with the majority (53.2%) having resided as inpatients in their respective facilities for more than 2 years. Two of these forensic inpatients, at any point in time, may be awaiting transfer within their respective facility, from a protected / integrated bed to a Regional Forensic bed.

Utilization data were incomplete (not readily retrievable) for "flow through" for protected / integrated beds during a consecutive 12-month time frame for 2001/02. Data on leaves of absence from the facility were also not readily retrievable and, therefore, are incomplete.

iii. Flow Out of the Facility

a. Regional Forensic Beds

The results, of the Snapshot Survey also suggest that, at any point in time, 65 (12.8%) of forensic secure inpatients may be clinically suitable (and have legal approval) for: a) care in / from another facility or in / from a community-based agency; or b) return to court or jail. The majority (84.6%) may be waiting to be discharged / transferred from their respective facility for 1 month to 1 year. The results further suggest that, during any consecutive 12-month time frame, 882 forensic inpatients may be transferred / discharged from their respective designated secure bed to court; jail, another health care facility, a community-based agency, or an accommodation in the community.

b. Protected / Integrated Beds

The Survey was unable to determine "flow out" of the facility or leave of absence utilization from protected / integrated beds at any point in time in 2001/02 (incomplete data). Responses to the Survey indicated that these data is not readily retrievable.

iv. Out of Facility

a. Regional Forensic Beds

The existence of an adequate community service system for forensic clients is critical to the successful return to and safe placement of the forensic client in the community.[17] Survey respondents, in addressing the top issues facing their respective regional forensic services identified inadequate community supports (e.g., diversion, housing), links and service integration as current key issues.

The survey results suggest that, at any point in time, the mental health facilities may be following 3,344 active forensic outpatients. The survey was unable to determine how active these outpatients were or the intensity of services provided in their care. The survey was also unable to determine the total number of forensic clients who were newly registered or terminated from outpatient services during a consecutive 12-month time frame for 2001/02.

b. Protected / Integrated Beds

Responses to the Survey with respect to protected / integrated beds "out of facility" activities indicated that these data is not readily retrievable.

v. Demand vs Capacity

Responses to the survey suggest that the forensic mental health system is dependent on the goodwill of the facilities to continue to use their general adult mental health beds to accommodate forensic clients. These 158 beds, when added to the total number of designated Regional Forensic beds (657), to be staffed and funded by 2003, suggest a total bed capacity of 815 forensic beds.

The survey results suggest that, should these protected / integrated beds not be formally recognized as forensic priority beds on a provincial basis, the supply versus demand for these beds (i.e., 657 designated forensic beds minus 709 forensic inpatients) might net out at a minus 52 beds. The results also suggest that, provincially, these 657 beds might have to meet the needs of:

a) 85 forensic clients, who might be awaiting admission;
b) 23 who might be awaiting transfer within their respective facility;
c) 65 who might be awaiting discharge / transfer out of their respective facility;

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[17] Forensic Policy Review: Summary of Findings from Stakeholder Consultations. MOHLTC, Ontario. 2000; p.5.

d) 34 who might be on a leave of absence, ready to return to a forensic bed at the end of their leave;

e) 3,344, who may be registered as active outpatients. These outpatients, at any time, could command special consideration for admission to a forensic bed; and

f) 6% to 8% of the inmates occupying the Ministry of Public Safety and Security's 8,995 beds / cells who have a serious mental illness and may require urgent access to MOHLTC's specialized inpatient programmes and services.

vi. Clinical Programming

a. Regional Forensic Beds

Consultations with the field helped develop the following "menu" of 13 treatment and 5 rehabilitation services befitting the potential needs of forensic clients while in the care of the designated facilities:

- ➢ Treatment
    - Brain Injured
    - Schizophrenia
    - Mood Disorder
    - Concurrent Disorder
    - Dual Diagnosis
    - Sex Offender
    - Family
    - Aging
    - Children and Youth
    - Anger Management
    - Crisis Response
    - Outreach
    - Outpatient Clinics

- ➢ Rehabilitation
    - Education
    - Employment
    - Housing
    - Recreation
    - Socialization

Through the above noted survey, facilities were asked to report on the provision and accessibility of these services to their forensic clients.

The survey results suggest that inconsistency exists within and between facilities. For example, some of the facilities reportedly do **not** provide on-site specialty services for specialized populations, as follows:

- acquired brain injury (4);
- dual diagnosis (3);
- sex offenders (3);
- children & youth (6);
- concurrent disorders (1); and
- family (1).

Some do not provide crisis response services (2). Some do not have outpatient clinics (2). Some of the facilities which provide treatment and rehabilitation services on site may not provide ready access for the forensic client (5).

a. Protected / Integrated Beds

The survey results suggest that the findings noted for the protected / integrated beds are remarkably similar to those noted for the designated Regional Secure beds.

vii. Human Resources / Staffing

a. Regional Forensic Beds

Significant resources are expended annually by the MOHLTC to staff and fund Ontario's forensic mental health inpatient system. The 10 designated facilities reported in their response to the above noted survey that, during the fiscal year ending March 31st, 2002, approximately 922 full time equivalents in direct care staff were assigned to their designated forensic beds. For the same time period, they also reported expending approximately $54 million in salary dollars (i.e., direct care, administration and administration support staff salaries). The survey was unable to roll up any other staffing and / or other direct operating cost findings (data were not readily retrievable).

Recruitment and retention of mental health specialists was also listed by some of the survey respondents as a current key issue. Consultations with the field helped develop a minimum list of 5 human resource benefits (i.e., personal growth and development opportunities) that, if afforded staff of the designated facilities, would aid in their retention and in the recruitment of others. Through the survey, the facilities were asked to report on the provision and accessibility of these opportunities to their forensic service staff. Inconsistency was reported in the provision of sabbaticals. One facility does not offer sabbaticals to any of its staff. Five offer sabbaticals to some of their staff, while not offering sabbaticals to their forensic staff. All ten offer training and education, clinical research, and temporary assignments to their forensic staff. Nine offer clinical teaching opportunities to their forensic staff.

b. Protected / Integrated Beds

The survey results suggest that the findings noted for the protected / integrated beds are remarkably similar to those noted for the designated Regional Secure beds.

C. KEY ISSUES

Survey participants identified a number of issues which were specific to their situation and regionally focused (e.g., need to integrate and coordinate two Regional Forensic Programs located in two different communities).

They also identified a number of provincially focused issues, such as the need for:

a) more resources (e.g., community supports, diversion services, etc.);
b) standardized security policies and procedures;
c) a forensic data base and management information system;
d) program evaluation standards;
e) a professional recruitment and retention strategy;
f) standardized training in risk management, risk assessment, etc.;
g) increase in services for specialized, forensic populations (i.e., young offenders, Aboriginals, and developmentally disabled);
h) an integrated approach to care, across all provider groups, agencies and Ministries; and
i) a change in service / catchment area, mandates from provincial to regional, in scope.

APPENDIX E

PART XX.1 / MENTAL DISORDER CRIMINAL CODE (CANADA)

Glossary[18]

"absolute discharge"[19]

means a disposition made by a court or Review Board directing the release of a not criminally responsible accused from any form of supervision under Part XX.1 of the Criminal Code (Canada); this disposition is not available to an unfit accused.

"accused"

includes a defendant in summary conviction proceedings and an accused in respect of whom a verdict of not criminally responsible on account of mental disorder has been rendered; includes a defendant in respect of whom an assessment order has been made or a defendant who has been found unfit to stand trial.[20]

"appeal"

means an appeal under s. 672.72 from a court or Review Board disposition made in respect of an accused to the Court of Appeal for a province.

"assessment"

means an assessment by a medical practitioner of the mental condition of the accused pursuant to an assessment order made under s. 672.11 and any incidental observation or examination of the accused; the possible orders include an assessment as to whether the accused is unfit to stand trial; whether the accused at the time of the commission of the alleged offence was suffering from a mental disorder so as to be exempt from criminal responsibility by virtue of ss.16(1); whether the balance of the mind of the accused was disturbed a the time of the commission of the alleged offence, where the accused is a female person charged with an offence arising out of the death of her newly-born child; the appropriate disposition to be made, where a verdict of not criminally responsible on account of mental disorder or unfit to stand trial has been rendered in respect of the accused.

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[18] Unless otherwise noted, the definitions in this Glossary are taken from s.672.1 of the *Criminal Code (Canada)*. All other statutory references are to the *Criminal Code (Canada)*.

[19] This definition only applies in the mental disorder context and does not have the same meaning as an absolute discharge granted to an offender who pleads guilty to or is found guilty of an offence. See Section 672.54(a) and 730.

[20] Sections 672.11, 672.22 - .37

"conditional discharge"[21]

means a disposition made by a court or Review Board directing that the accused be discharged, subject to such conditions as the court or Review Board considers appropriate; this disposition is available to an unfit or not criminally responsible accused.

"custody in a hospital"[22]

means a disposition made by a court or Review Board directing that the accused be detained in the custody of a hospital, subject to such conditions as the court or Review Board considers appropriate; this disposition is available to an unfit or not criminally responsible accused.

"disposition"

means an order made by a court or the Review Board under s.672.54 for an accused's custody or discharge, or an order made by a court under s.672.58 for the treatment of an unfit accused.

"dual status offender"

means an offender who is subject to a sentence of imprisonment in respect of one offence and a custodial disposition under s.672.54(c) in respect of another offence.

"hospital"

means a place in a province that is designated by the Minister of Health and Long-Term Care for the province for the custody, treatment or assessment of an accused in respect of whom an assessment order, a disposition or a placement decision is made.

"judicial interim release"

means an order made by a court for the interim release of a person charged with an offence, usually subject to conditions, pending his or her trial or other disposition.

"mental disorder"[23]

means a disease of the mind.

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[21] This definition only applies in the mental disorder context and does not have the same meaning as a conditional discharge granted to an offender who pleads guilty to or is found guilty of an offence. See Section 672.54 (b) and 730.

[22] Section 672.54 (c)

[23] Section 2

"prosecutor"[24]

means the Attorney General or, where the Attorney General does not intervene, means the person who institutes proceedings to which the Criminal Code of Canada applies, and includes counsel acting on behalf of either of them.

"not criminally responsible"[25]

means no person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong.

"placement decision"

means a decision by a Review Board under ss.672.68(2) as to the place of custody of a dual status offender; the possible places of custody are a hospital designated under the mental disorder part of the Criminal Code or a correctional facility.

"unfit to stand trial"[26]

means unable on account of mental disorder to conduct a defence at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, and, in particular, unable on account of mental disorder to:

(a) understand the nature or object of the proceedings,
(b) understand the possible consequences of the proceedings,
(c) communicate with counsel.

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[24] Section 2
[25] Section 16
[26] Section 2